

Risk Factors Comparison 2024-03-06 to 2023-03-08 Form: 10-K

Legend: **New Text** ~~Removed Text~~ Unchanged Text **Moved Text** Section

Risks Related to Our Business and Industry • ~~Our business depends upon the success of our proprietary platform. • Our limited operating history may make it difficult to evaluate the success of our business. • We have incurred significant losses since inception, and we expect to incur losses over the next several years and may not be able to achieve or sustain revenues or profitability in the future. •~~ **Our business depends upon the success of our proprietary platform. • Our limited operating history may make it difficult to evaluate the success of our business to date and to assess our future viability. • We have never generated, and may never generate, any revenue from sales of our cell-TCR- T therapy candidates, and our ability to generate revenue from product sales and become profitable depends significantly on our success in a number of areas. • We will need to obtain substantial additional funding to complete the development and any commercialization of our product candidates, if approved. • If we are unable to raise this necessary capital when needed, we would be forced to delay, reduce or eliminate our product development programs, commercialization efforts or other operations. • Raising additional capital may cause dilution to our existing stockholders, restrict our operations or require us to relinquish rights to our intellectual property or product candidates on unfavorable terms to us. • Global economic uncertainty and financial market volatility caused by political instability, changes in international trade relationships and conflicts, such as the ongoing conflict between Russia and Ukraine, could make it more difficult for us to access financing and could adversely affect our business and operations. • Recent volatility in capital markets and lower market prices for many securities may affect our ability to access new capital through sales of shares of our common stock or issuance of indebtedness, which may harm our liquidity, limit our ability to grow our business, pursue acquisitions or improve our operating infrastructure and restrict our ability to compete in our markets. • Adverse developments affecting the financial services industry, such as actual events or concerns involving liquidity, defaults or non-performance by financial institutions or transactional counterparties, could adversely affect our current and projected business operations and its financial condition and results of operations. • The terms of our loan agreement place restrictions on our operating and financial flexibility. If we raise additional capital through debt financing, the terms of any new debt could further restrict our operating and financial flexibility.**

Risks Related to the Development of Our Product Candidates • Our approach to the discovery and development of product candidates based on our proprietary platform represents a novel approach to cancer treatment, which creates significant challenges for us. • **We are early in our development efforts.** If we are unable to advance our product candidates through clinical development, obtain regulatory approval and ultimately commercialize our product candidates, or experience significant delays in doing so, our business will be materially harmed. • Although many of our personnel have extensive experience in ~~preclinical and~~ clinical development and manufacturing at other companies, we have ~~no~~ **limited** direct experience as a company in conducting clinical trials ~~or and~~ managing a manufacturing facility for our product candidates. • Our preclinical studies and clinical trials may fail to ~~demonstrate~~ **demonstrate** adequately the safety, potency and purity of any of our product candidates, which could prevent or delay the development, regulatory approval and commercialization ~~of our product candidates~~. • Our business could be adversely affected by the effects of health epidemics, including **any ongoing public health crises, in regions where we, our partners or the other evolving effects third parties on which we rely have significant manufacturing facilities, concentrations of potential clinical trial sites or the other business operations** COVID-19 pandemic and responses thereto. • We may rely on third parties to manufacture our clinical product supplies, and we may rely on third parties to produce and process our product candidates, if licensed. • Allogeneic **hematopoietic cell transplantation (HCT)** is a high- risk procedure that may result in complications or adverse events for patients in our clinical trials including those unrelated to the use of our product candidates, or for patients that use any of our product candidates, if approved. • Our product candidates may cause undesirable side effects or have other properties that could halt their clinical development, prevent their regulatory approval, require expansion of the ~~clinical~~ trial size, limit their commercial potential, or result in ~~other~~ significant negative consequences. • If we encounter difficulties enrolling patients in our clinical trials, our clinical development activities could be delayed or otherwise adversely affected. • The market opportunities for our product candidates may be relatively small **as they will be limited to those patients who are ineligible for or have failed prior treatments** and our estimates of the prevalence of our target patient populations may be inaccurate. • We face significant competition, and our operating results will suffer if we fail to compete effectively.

Risks Related to Manufacturing • Manufacturing and administering our product candidates is complex and we may encounter difficulties in production of, **particularly with respect to process development our- or product scaling up of our manufacturing capabilities. If we encounter such difficulties, our ability to provide supply of our TCR- T therapy candidates for clinical trials or for commercial purposes could be delayed or stopped.** • Although we have expanded our existing manufacturing facility and infrastructure in lieu of relying solely on third parties for the manufacture of our product candidates for certain clinical purposes and many of our personnel have experience in clinical manufacturing at other companies, we have ~~limited no direct~~ **limited** no direct experience as a company managing manufacturing for our product candidates, which will be costly and time- consuming, and which may not be successful. • We may have difficulty validating our manufacturing process as we manufacture our product candidates, including TCR- **Ts T**, from ~~the~~ **an increasingly diverse** patient population for our clinical trials.

Risks Related to Government Regulation • The **U. S. Food and Drug Administration, or FDA,** regulatory approval process is lengthy and time- consuming, and we may experience significant delays in the ~~preclinical and~~ clinical development and regulatory approval of our product candidates. • We may be unable to obtain regulatory approval for our product candidates under applicable regulatory requirements. **The denial or delay of any such approval**

would delay commercialization of our product candidates and adversely impact our potential to generate revenue, our business and our results of operations.

- Obtaining and maintaining regulatory approval of our product candidates in one jurisdiction does not mean that we will be successful in obtaining and maintaining regulatory approval of our product candidates in other jurisdictions.

Risks Related to Our Intellectual Property

- If we are unable to obtain and maintain patent protection for any of the product candidates we develop and for our technology, or if the scope of the patent protection obtained is not sufficiently broad, our competitors could develop and commercialize products, product candidates and technology substantially similar or identical to ours, and our ability to successfully commercialize any product candidates we may develop, and our technology may be adversely affected.
- We are currently, and expect in the future to be, party to material license or collaboration agreements, which may impose numerous obligations and restrictions on us.
- Third-party claims of intellectual property infringement, misappropriation or other violations may prevent or delay our product discovery and development efforts.

Risks Related to Our Reliance on Third Parties

- ~~If the~~ **We plan to rely on** third parties ~~we plan to rely on~~ to conduct our clinical trials. **If these third parties** ~~or to manufacture certain aspects of our product candidates~~ do not properly and successfully carry out their contractual duties or meet expected deadlines, we may not be able to obtain regulatory approval for ~~of~~ or commercialize our product candidates.
- We **have in the past and may in the future form or seek collaborations or strategic alliances or enter into additional licensing arrangements, and we** may not realize the benefits of ~~such~~ **our current or future** collaborations, alliances, or licensing arrangements.

General Risk Factors

Rising inflation rates may result in increased operating costs and reduced liquidity, and affect our ability to access credit.

PART I Item 1. Business Overview

We are a clinical-stage biopharmaceutical company focused on developing a robust pipeline of T cell receptor (TCR)-engineered T cell, or TCR-T, therapies for the treatment of patients with cancer. Our approach is based on the central premise that we can learn from patients who are winning their fight against cancer in order to treat those who are not. **We are continuing to Over the past several years, we have build-built** our ImmunoBank, a repository of therapeutic T cell receptors, or TCRs, that recognize diverse targets and are associated with multiple human leukocyte antigen, or HLA, types. **These TCRs are then used to manufacture enhanced** provide customized multiplexed TCR-T therapy **therapies candidates for to treat a broad population of** patients with a variety of **both heme and solid tumors- tumor malignancies**. We are building **Every TCR in our ImmunoBank using has come from** our proprietary platform technologies, **and we are continuing to expand our ImmunoBank**. Using TargetScan, we analyze the T cells of cancer patients with exceptional responses to immunotherapy to discover how the immune system naturally recognizes and eliminates tumor cells in these patients. This allows us to precisely identify the targets of TCRs that are driving these exceptional responses. We **then aim to** use these anti-cancer TCRs to treat patients ~~with cancer~~ by genetically engineering ~~their own~~ T cells to recognize and eliminate their cancer. In addition to discovering ~~TCR-TCRs~~ T therapies against novel targets, we are using our ReceptorScan technology to **identify high affinity naturally occurring** further diversify our portfolio of therapeutic TCRs **for** with TCR-T therapies against known targets. **We Once we identify therapeutic candidates using these technologies, we** reduce the safety risk and enhance the safety profile of **clinical development by comprehensively screening** these therapeutic TCRs **against** by screening them **the human proteome** using SafetyScan to identify potential off-targets **target of a interactions. We then eliminate any TCR-T and eliminate those TCR-candidates that cross-react with proteins expressed at high levels in critical organs normal tissues**. Our in-house good manufacturing practices, or GMP, **manufacturing-T-cell engineering** platform, which we refer to as T-Integrate, enables the rapid, cost-effective, and consistent manufacturing of TCR-Ts. Our TCR-T ~~therapy~~ candidates are manufactured using a non-viral transposon/transposase system. This system is highly reproducible and can be routinely **manufactured applied to new TCR-T candidates** in a cost-effective manner without the need for extensive process development. The ~~additional~~ **larger** cargo capacity of our non-viral vector delivery system allows us to **add-include** additional T cell enhancements **to-in** our product candidates ~~to provide support~~. **In both our heme and solid tumor programs, we are introducing the gene for CD8 α / β along with the TCR gene, which enables us to engineer both cytotoxic and helper T cells. We believe this enhancement has the potential to improve responses to TCR-T therapy in the clinic compared to engineering cytotoxic T cells alone.** By adding CD8 α / β **In our solid tumor program**, we believe we have the potential to increase response to TCR-T therapy up to four-fold in the clinic compared to the addition of the TCR alone. We are also adding a dominant-negative (DN) form of TGF β RII to **enable-our T cell-cells, which enables them to proliferation proliferate** despite the presence of TGF β in the hostile tumor microenvironment. **This has the potentially-- potential to enhancing-enhance** T cell persistence. Our GMP facility has the **estimated** capacity to manufacture clinical trial materials for more than 300 patients **up to 250 TCR-T components** per year, sufficient to support **all of** our programs through Phase 2 clinical development. We are advancing a robust pipeline of TCR-T ~~therapy~~ candidates for the treatment of patients with hematologic malignancies and solid tumors. Our lead product candidates, TSC-100 and TSC-101, are in development for the treatment of patients with hematologic malignancies to eliminate residual ~~leukemia~~ **disease** and prevent relapse following **allogeneic** hematopoietic cell transplantation (~~or~~ HCT). TSC-100 and TSC-101 target **the antigens** HA-1 and HA-2 antigens, respectively, which are well-recognized TCR targets that were **first** identified in patients with exceptional responses to HCT-associated immunotherapy. We have initiated a multi-arm Phase 1 **"umbrella"** clinical study of TSC-100 and TSC-101 with **several-over ten** clinical sites activated, ~~with planned additional~~ **and we plan to add more** sites ~~to be added~~ in 2023-2024. In addition, we are developing multiple TCR-T ~~therapy~~ candidates for the treatment of solid tumors. One of the **challenges of treating** key goals for our solid **tumors is that they are heterogeneous- not every tumor program is to cell expresses a given target and some tumor cells lose half their HLA genes. To address this challenge, we are develop developing** what we refer to as multiplexed TCR-T therapy **- treating a patient with more than one TCR-T candidate at a time**. We are designing these multiplexed therapies to be a ~~combination~~ **simultaneous administration** of up to three highly active ~~TCRs~~ **TCR-T therapy candidates, selected from our ImmunoBank,** that are customized for each patient **based on** and selected from our bank of therapeutic TCRs, which we refer to as **targets are expressed in the their ImmunoBank tumors**

and which HLA genes are still intact. We plan to continue to populate and prioritize expanding the ImmunoBank with TCRs for multiple targets and as well as multiple HLA types for each target, thus helping us to overcome key solid tumor resistance mechanisms of target loss and HLA loss. We are currently advancing and have now advanced six TCR solid tumor programs: TSC- 204, entering T therapy candidates into Phase 1 development for solid tumors: TSC- 203- A0201 (PRAME, HLA- A * 02: 01); TSC- 200 and TSC- 203- A0201 (HPV16, HLA in-IND- enabling activities- A * 02: 01); TSC- 201 - B0702 (MAGE- C2, in lead optimization- HLA- B * 07: 02); and TSC- 204- A0201 (MAGE- A1, HLA- A * 202- 02 and- 01); TSC- 205- 204- C0702 (MAGE- A1, in discovery- HLA- C * 07: 02); and TSC- 204- A0101 (MAGE- A1, HLA- A * 01: 01). In December 2022, we submitted a primary addition to clearing these six solid- tumor investigational new drug (, or-IND) applications, the FDA has cleared our IND application for T- Plex, enabling customized mixtures of us to treat patients with multiplexed TCR- Ts T therapy. We plan to further expand be administered to patients based on cancer- targets and associated common HLA types expressed in their -- the ImmunoBank in 2024 by filing tumors, as well as secondary-IND applications for additional two initial-TCR- Ts T product candidates: TSC- 204- A0201 and TSC- 204- C0702. The FDA has cleared our IND applications for T- Plex, TSC- 204- A0201, and TSC- 204- C0702, allowing us to initiate study start- up activities. We plan to further expand the ImmunoBank by filing INDs for additional TCRs throughout 2023. T cells are an essential component of the adaptive immune system and provide protection against cancer, infection, and autoimmune disease disorders. Multiple approaches have been and are continuing to be explored to develop effective T cell- based therapies for the treatment of cancer, including checkpoint inhibitor therapy, tumor infiltrating lymphocyte, or TIL, therapy, and chimeric antigen receptor (CAR) T cell, or CAR- T, therapy. The success of checkpoint inhibitor and TIL therapy depends on the specific T -cells present in the patient. If their TILs T- cells do not have appropriate anti- cancer specificities, the therapy is unlikely to be effective. In addition, TIL therapy has, to date, shown limited applicability for the treatment of hematologic malignancies. In contrast, CAR- T therapy has proven effective in certain hematological malignancies of lymphoid origin but have- has not yet shown efficacy or safety in myeloid malignancies or solid-. Additionally, this type of treatment is limited to targets on the surface of tumor tumors cells and carries higher toxicity risks such as cytokine release syndrome compared with TCR- T therapy due to the CAR- T therapy's artificial intracellular signaling domains and excessive stimulation of T cells. Both TIL and CAR- T therapies, as well as other immunotherapies such as checkpoint inhibitors, harness the power of cytotoxic T cells in fighting cancer. Despite demonstrating compelling efficacy, they are only effective in a subset of patients. To address a broader patient population, we believe additional T cell- based approaches are needed that more closely mimic the way the immune system recognizes and fights cancer in patients who are responding to immunotherapy. The successful development of Two key shortcomings in the TCR - Ts field remain: Low response rates, and limited duration of response. These shortcomings are related to solid tumors being heterogenous, and poor persistence of engineered T cells in patients. We believe we can overcome these known issues by adding enhancements to our product candidates, such as has the addition of CD8 α / β to improve persistence compared to CD8 α alone. We are also co- introducing DN- TGF β RII, which is designed to overcome immunosuppression from TGF β in the tumor microenvironment. Our decision to develop TCR- T therapies for the treatment of cancer is based on our conviction that we can learn from the natural interaction between T cells and tumor cells and harness this information to treat patients by reprogramming their immune systems. We believe that TCR- T therapy combines the benefits of TIL and CAR- T therapies while uniquely addressing their key limitations. The development of TCR- T therapy requires three key prerequisites: (i) an effective anti- cancer TCR; (ii) knowledge of the precise peptide antigen, a protein or other molecule to which an antibody binds, that is recognized by the TCR; and (iii) confirmation that the TCR does not recognize problematic off- targets. We believe that our approach provides us with the following key advantages: • Our TCR- Ts T therapies are based on highly active TCRs that are clinically relevant. Many other approaches to T cell therapy rely on specifically expanding T cells that are already present in the patient. Our platform analyzes anti- cancer T cells from a wide variety- broad set of individuals, including patients who are responding to immunotherapy in order- as well as healthy donors, to find the most active and clinically relevant TCRs against each target. We believe that we can develop TCR- Ts T therapies for a wide range of patients, including those who do not have T cells that efficiently recognize their cancers. • Our TCR- Ts T therapies are designed to be used in combination with each other. We are building- have built the ImmunoBank of TCRs to allow for multiplexed TCR- T therapy, which has the potential to address the heterogeneous nature of solid tumors and to prevent resistance developing due to target or HLA loss of a single target. We continue believe this approach may allow us to expand overcome the limitations and challenges of TCR- T therapy development to date. We plan to populate the ImmunoBank with TCRs for multiple targets as well as multiple common HLA types for each target, thus helping us to overcome the key solid tumor resistance mechanisms of target loss and as well as HLA loss. • Our approach is expandable. The ImmunoBank has the flexibility to be used with new and optimized methods of T cell engineering that we may develop over time. We are building- currently employing the ImmunoBank to validated approach of patient- specific ex vivo engineering, but as the field evolves, our TCRs may be compatible with both autologous and allogeneic engineering technologies in order to potentially transition- transitioned to generating " off- the- shelf " methods, including allogeneic T cells that have been pre- engineered with our- or in vivo engineering TCRs for direct, customized administration to patients. As we expand the ImmunoBank to include TCRs across additional targets and HLA types, we believe we will increase the eligible patient population for our clinical trials, which will allow for rapid and efficient clinical trial enrollment with fewer screen failures. Our proprietary platform is designed to: (i) discover anti- cancer TCRs from patients with exceptional responses to immunotherapy; (ii) determine novel targets of clinically relevant TCRs; (iii) discover novel TCRs that recognize clinically validated targets; (iv) identify off- targets- target interactions of TCRs to eliminate candidates that could potentially pose a safety risk; and (v) manufacture TCR- Ts T therapies efficiently and consistently without the use of viral vectors using our T- Integrate technology. The central elements of our platform that we believe differentiate us from other cell therapy companies are TargetScan, ReceptorScan, SafetyScan, the ImmunoBank, and T- Integrate. TargetScan. At the core of our proprietary platform is TargetScan, which enables us to identify

natural targets of TCRs using an unbiased, genome-wide, high-throughput screen. We have developed this technology to be extremely versatile and applicable across multiple therapeutic areas, including cancer, autoimmune disorders, and infectious diseases. It can be applied to virtually any TCR that plays a role in the cause or prevention of disease. Using TargetScan, we have identified ~~about 100~~ **approximately 200** novel antigens as targets of tumor-infiltrating T cells from patients who are actively responding to immunotherapy. We believe this provides us with a competitive advantage, because not only are we among the first to identify these targets as tumor-specific antigens, but ~~also~~ we have **also** already identified highly active TCRs that recognize these targets. **Two SafetyScan. SafetyScan is designed to identify potential off- of our pipeline programs emerged from TargetScan: TSC- target interactions of a given TCR- 201- B0702 (MAGE- C2, HLA- B * 07: 02) and eliminate TSC- 204- C0702 (MAGE- A1, HLA- C * 07: 02), those-- the latter TCR-candidates that cross-react with proteins expressed at high levels in critical organs. We believe this will allow us to reduce the risk and enhance the potential safety profile of which was featured our TCR- T therapy candidates early in development before we initiate clinical trials-- the peer-reviewed journal Cell in 2022.** ReceptorScan. To further expand our ability to discover and develop therapeutic TCRs, we have developed our proprietary ReceptorScan technology to enable us to identify and clone highly active TCRs that recognize known or clinically validated targets. We co-culture hundreds of millions of CD8 T cells from either healthy donors or cancer patients with dendritic cells, also referred to as antigen-presenting cells, that display the target antigen of interest to the T cells. T cells that recognize the target of interest proliferate and are subsequently isolated based on their ability to recognize a fluorescently labeled version of the target. We then use single cell sequencing to identify the specific TCR sequences that recognize the target. Our novel technologies allow us to gene-synthesize hundreds of TCRs simultaneously and to rapidly sort through hundreds of target-specific TCRs in a single high-throughput screen to identify the most active clones. Using ReceptorScan, we have identified our two lead TCR- T therapy-candidates, TSC- 100 targeting HA- 1 and TSC- 101 targeting HA- 2, as well as ~~our several other pipeline programs~~, **including TSC such as the MAGE- A1- 203 - A0201 (PRAME, HLA- A * 02: 01) and TSC- 200- A0201 (HPV16, HLA- A * 02: 01). SafetyScan. SafetyScan is designed to identify potential off-targeting--- target interactions of a given TCR and eliminate those TCR candidates that has now become cross-react with proteins expressed at high levels in normal tissue. We believe this will allow us to reduce the risk and enhance the potential safety profile of our solid tumor therapeutic TCR- T candidate-candidates early-- TSC- 204- C0702, featured in development before we initiate clinical trials the peer-reviewed journal Cell in 2022.** ImmunoBank. We are **building expanding** the ImmunoBank, our diverse ~~bank-repository~~ **bank-repository** of therapeutic TCRs, to allow for multiplexed TCR- T therapy, which has the potential to address the heterogeneous nature of solid tumors and to prevent resistance developing due to loss of a single HLA haplotype target. We believe this approach may allow us to overcome the limitations and challenges of TCR- T therapy development to date. We ~~plan continue to populate~~ **prioritize expanding** the ImmunoBank with TCRs for multiple targets as well as multiple HLA types for each target, thus helping us to overcome the key solid tumor resistance mechanisms of target loss ~~and as well as HLA loss~~. Finally, we are **building expanding** the ImmunoBank to have the flexibility to be used with new and optimized methods of T cell engineering that we may develop over time. We ~~are building~~ **have built** the ImmunoBank to be compatible with ~~both autologous and~~, **allogeneic**, **and in vivo** engineering technologies in order to potentially transition to generating off-the-shelf **products**, ~~allogeneic T cells that have been pre-engineered with our TCRs~~ for direct, customized administration to patients. T- Integrate. Manufacturing cell therapies is highly complex, and associated challenges have led to significant delays or failures in the development of many cell therapies. To enable the rapid, cost-effective, and consistent manufacturing of TCR- Ts, we have developed a non-viral vector delivery system that we refer to as T- Integrate. Our TCR- T therapy-candidates are manufactured using a transposon / transposase system, in which the DNA encoding the TCR is manufactured as a Nanoplasmid™, a non-viral vector. The Nanoplasmid, together with an mRNA sequence encoding a transposase enzyme, is introduced into the T cell by electroporation. After the T cell translates the mRNA into protein, the transposase enzyme inserts the TCR sequence from the Nanoplasmid, **as well as any enhancements such as CD8a / b and DN- TGFβRII**, into the genome of the T cell. This system is highly reproducible, as the only required components are a Nanoplasmid, which is different for each TCR product, and an mRNA, which is constant for all TCR products. Unlike lentivirus, both ~~of these~~ components are routinely manufactured in a cost-effective manner without the need for extensive process development. We have completed the construction and ~~validation~~ **qualification** of a 7,000 square-foot state-of-the-art GMP manufacturing facility to manufacture all necessary Phase 1 and 2 supply for our TCR- ~~Ts T therapies~~. We expect that this facility will provide sufficient production capacity to supply product for all planned Phase 1 and 2 clinical studies for the hematologic malignancies and solid tumor programs. ~~Clearance of our INDs for TSC- 100 and TSC- 101 validates our facility for human manufacturing of our T cell therapies.~~ We believe our manufacturing platform will enable us to efficiently develop and manufacture many different TCR- ~~Ts T therapies~~, allowing us to deliver customized multiplexed therapy to patients with cancer. ~~We As of February 28, 2023, we have successfully manufactured TSC- 100 and TSC- 101 but and have not yet dosed patients in our hematological malignancies program. The FDA has additionally cleared three seven INDs-- IND applications for our solid tumor program, including our primary IND --application T- Plex, which supports the simultaneous use of multiple TCRs-- TCR- Ts to create customized --multiplexed TCR- T therapy candidates, as well as INDs-- IND applications for TSC- 200- A0201 (HPV16, HLA- A * 02: 01), TSC- 201- B0702 (MAGE- C2, HLA- B * 07: 02), TSC- 203- A0201 (PRAME, HLA- A * 02: 01), TSC- 204- A0201 and (MAGE- A1, HLA- A * 02: 01), TSC- 204- C0702 (MAGE- A1, HLA- C * 07: 02), and TSC- 204- A0101 (MAGE- A1, HLA- A * 01: 01), in our view further validating our manufacturing capabilities. Our Pipeline We are building expanding the ImmunoBank with the goal of delivering customized multiplexed TCR- T therapies therapy to a wide range of patients with cancer. In addition, we are applying our platform to identify targets and TCRs in therapeutic areas outside of oncology, such as autoimmune disorders and infectious disease, through strategic partnerships. Our current proprietary pipeline is summarized in the figure below. In addition to our proprietary pipeline programs noted above, we have also entered into collaborations with strategic partners for applications of our platform technologies. We have a~~

collaboration and license agreement with Amgen, Novartis Institutes for Biomedical Research, Inc., or Novartis Amgen, to identify the novel cancer antigens from the recognized by T cells of in patients with Crohn's disease a certain specific type of cancer. Amgen will evaluate a variety Novartis has the option to license and develop therapies for up to three of the modalities to create therapeutic candidates based on targets discovered in the collaboration by TScan and will retain all global development and commercial rights. With our differentiated platform as the foundation, we are building a three-pillar research and development strategy to create transformational TCR- T therapies for patients. 1. Our Hematologic Malignancies Program. We are developing our hematologic malignancies program TCR- T therapies to treat patients with heme non-B cell malignancies, including acute myeloid leukemia, or AML, myelodysplastic syndromes -, or MDS, and acute lymphocytic leukemia, or ALL, who are undergoing allogeneic HCT. In the first phase of our clinical development strategy, we are initially focusing on clinically validated cancer targets that have been discovered in patients with exceptional responses to HCT-associated immunotherapy, including HA- 1 and HA- 2. In the fourth quarter of 2021, we submitted IND applications with the FDA for our lead TCR- T therapy candidates, TSC- 100 and TSC- 101. In the first and second quarter of 2022, the FDA cleared the INDs for TSC- 100 and TSC- 101, respectively. We have initiated are currently enrolling patients in a multi-arm Phase 1 "umbrella" clinical study with several over ten clinical sites activated and with planned additional sites planned to be added in 2023-2024. The study protocol allows us to conduct clinical trials of TSC- 100 and TSC- 101 in parallel, with patients enrolled in treatment arms based on their genotype. Patients who are positive for the target antigen, HA- 1 or HA- 2, as well as the HLA- A * 02: 01 allele, which is the HLA type required to display HA- 1 and HA- 2 on the cell surface for recognition by a T cell, are will be eligible for enrollment. Furthermore, eligible Eligible patients will require donors who are negative for either the target antigen or the HLA- A * 02: 01 allele. Through the development of our hematologic malignancies program, we have built a foundation of manufacturing, clinical, and regulatory capabilities, which we are applying to the development of our broader portfolio of TCR- T therapy candidates for solid tumors. 2. Our Solid Tumor Program. We are developing a portfolio of autologous TCR- T therapy candidates that are designed to be used in combination with each other to treat and eliminate solid tumors. Our TSC- 200-20X series of product candidates are designed to elicit anti-tumor responses in patients by targeting cancer-specific antigens in their tumor cells. Our TCR- T therapy candidates include: (i) either well-recognized cancer targets that have demonstrated anti-tumor activity in clinical trials or novel targets that were identified by TargetScan from the T cells of patients responding to immunotherapy, and (ii) naturally occurring TCRs specific to a patient's HLA type that recognize these cancer-specific targets. Such targets are not only commonly shared among patients with the same cancer type, but also frequently expressed in multiple solid tumor types, enabling clinical development across multiple indications. Our first six product candidates include a combination of known targets, such as HPV16 for TSC- 200, the previously undisclosed target of MAGE- A4 for TSC- 202, PRAME for TSC- 203, and MAGE- A1 for TSC- 204, as well as a targets- target that are is a novel antigens- antigen for TCR- T therapy, such as MAGE- C2 for TSC- 201, TSC- 202, and TSC- 205. In addition to our six lead product candidates, we have identified about 100 approximately 200 novel antigens as targets of tumor-infiltrating T cells from patients who are responding to immunotherapy using our TargetScan technology. We are in early stages of analyzing these additional novel antigens and plan to advance those that we believe have the best potential as a TCR- T product candidate into preclinical development. Our vision is to create and continuously expand the ImmunoBank to enable customized multiplexed TCR- T therapy for a wide range of solid tumor patients. Our initial solid tumor indications include non-small cell lung cancer, head & neck cancer, melanoma, ovarian cancer, cervical cancer, non-small cell lung and ovarian anogenital cancers, as well as melanoma. For each patient with a solid tumor malignancy, we first plan to analyze their- the patient's tumor to determine which targets are expressed at high levels in each patient's particular cancer and which HLA genes are still intact. We will then access the ImmunoBank and select up to three TCRs that match their HLA type and address the most highly expressed targets in their tumor. We will use this set of TCRs to genetically reprogram their T cells to recognize these targets, and the resulting T cells will be infused back into the patient as a multiplexed TCR- T therapy. Enabled by the additional cargo capacity of our non-viral vector delivery system, we are also introducing enhancements to our product candidates to deepen tumor responses and prolong duration of response. By introducing the gene for CD8 α / β along with the TCR gene, we are able to engineer both cytotoxic and helper T cells which we believe has the potential to improve responses to treatment with TCR- T therapy in the clinic compared to engineering cytotoxic T cells alone. We are also adding a DN enhancements to our product candidates to deepen tumor responses and prolong duration of response. The additional cargo capacity of our non- TGF β RII viral vector delivery system allows us to add additional T cell enhancements to our product candidates to provide support for cytotoxic T cells. By adding CD8 α / β , which allows we believe we have the them potential to increase response to TCR- T therapy up to four-fold in the clinic compared to the addition of the TCR alone. We are also adding dominant-negative TGF β RII to enable T cell proliferation-proliferate despite the presence of TGF β in the hostile tumor microenvironment. This has the potentially- potential to enhance-enhance T cell persistence. 3. Strategic Partnerships and Collaborations. T cells play a fundamental role in many other therapeutic areas beyond cancer, such as autoimmune disorders and infectious diseases and infectious disease. We believe that our TargetScan technology is well suited to discover novel antigens for the development of therapeutics, diagnostics, and vaccines in these other therapeutic areas. We intend to opportunistically pursue collaborations with strategic partners for applications of our platform technologies outside our core focus of oncology. Our Strategy Our mission is to create life-changing TCR- T cell therapies for patients by unleashing the untapped potential of the human immune system. Our goal is to use our proprietary platform technologies for the identification of novel tumor-specific antigens and clinically active TCRs to become a leader in the development of engineered T cell therapies for the treatment of hematologic malignancies and solid tumors. Our strategy includes the following key elements: • Leverage our proprietary platform technologies to build the ImmunoBank of therapeutic TCRs to treat a wide range of tumor types. Our TargetScan technology enables us to identify novel antigens that are broadly expressed across multiple types of solid tumors. To In order to ensure that the antigens identified are clinically relevant, we use TCRs from tumor samples

of patients with exceptional responses to immunotherapy. Our platform allows us to assess the specificity and cytotoxicity of these TCRs to develop a portfolio of TCR- T therapy candidates with therapeutic potential. As we continue to expand our screening technology, we believe we will be able to generate fill the ImmunoBank of therapeutic TCRs with the diversity required to treat many solid tumors using multiplexed therapy. We plan continue to populate prioritize expanding the ImmunoBank with TCRs for multiple targets as well as multiple common HLA types for each target, thus helping us to overcome the key solid tumor resistance mechanisms of target loss and as well as HLA loss. • Advance our lead product candidates, TSC- 100 and TSC- 101, through clinical development. Our two lead programs, TSC- 100 and TSC- 101, are designed to target HA- 1 and HA- 2, respectively, both of which are antigens with clinically demonstrated anti- tumor effects in patients who naturally develop T cells specific to these targets. Using our ReceptorScan technology, we generated hundreds of highly active TCRs that recognize HA- 1 and HA- 2. We selected TSC- 100 and TSC- 101 based on their superior potency and lack of off- target effects. In the fourth quarter of 2021 we submitted INDs for each of TSC- 100 and TSC- 101 to the FDA. The FDA cleared the INDs for both TSC- 100 and TSC- 101 enabling us to move forward with Phase I clinical development. We have initiated are currently enrolling patients in a multi- arm Phase I clinical study of TSC- 100 and TSC- 101 with several over ten clinical sites activated, with planned additional sites planned to be added in 2023-2024. The study protocol allows us to conduct clinical trials of TSC- 100 and TSC- 101 in parallel, with patients enrolled in treatment arms based on their genotype. In addition, through our hematologic malignancies programs- program, we have established a foundation of manufacturing, clinical and regulatory capabilities to support the development of our broad portfolio of TCR- Ts T therapies. • Apply experience from our hematologic malignancies program to efficiently develop our solid tumor program targeting both novel and previously identified antigens. Using TargetScan, we have identified about 100 novel antigens as targets of tumor infiltrating T cells from patients who are responding to immunotherapy. We are initially developing our TSC- 200-20X series of TCR- Ts T therapies against six- five selected target antigens that are frequently expressed across multiple solid tumor types. Our first six solid tumor TCR- T therapy candidates include a combination of known targets, such as HPV16 for TSC- 200, MAGE- A4 for TSC- 202, PRAME for TSC- 203, and MAGE- A1 for TSC- 204, as well as a targets- target that are is a novel antigens- antigen for TCR- T therapy, such as MAGE- C2 for TSC- 201, TSC- 202, and TSC- 205. We believe that the treatment of solid tumors will require a combination of several TCR- T therapeutics- therapeutic TCRs, which we refer to as ‘ multiplexed therapy’. We plan to leverage the foundation built from our hematologic- heme malignancies programs- program to efficiently develop a robust portfolio of TCR- T therapy candidates and expand the ImmunoBank to enable multiplexed TCR- T therapies- therapy for the treatment of solid tumors. • Maintain internal manufacturing capabilities based on our non- viral T- Integrate system. We believe that in- house manufacturing capabilities substantially facilitate the successful early development of cell therapies. For our TCR- T therapy candidates, we have developed a non- viral gene delivery system, which we refer to as T- Integrate, based on transposons that are designed to enable cost- effective and consistent cell manufacturing with short development times. We have built an internal, fully operational GMP manufacturing facility that we expect will provide sufficient capacity to support all of our clinical programs in both hematologic- heme malignancies and solid tumors through Phase 2 clinical trials. The additional cargo capacity of our non- viral vector delivery system allows us to add additional- T cell enhancements to our product candidates to provide support. By introducing the gene for CD8a / β along with the TCR gene, we are able to engineer both cytotoxic and helper T cells, which we believe has the potential to improve responses to TCR- T therapy in the clinic compared to engineering cytotoxic T cells. By adding CD8a / β, we believe we have the potential to increase response to TCR- T therapy up to four- fold in the clinic compared to the addition of the TCR alone. We are also adding dominant a DN- negative- TGFβRII to enable T cell cells, which enables them to proliferation proliferate despite the presence of TGFβ in the hostile tumor microenvironment. This has the potentially- potential to enhancing- enhance T cell persistence. With the FDA clearance of our IND applications for TSC- 100, TSC- 101, and our seven first three- IND applications for our solid tumor program, including our primary IND application, T- Plex, we consider our approach to be validated. • Develop next generation T cell engineering capabilities. Our long- term vision is to build an- develop off- the- shelf products, either through allogeneic repository of off- the- shelf, genetically engineered T- cells- cell engineering or in vivo engineering, and provide customized multiplexed TCR- T therapies- therapy to patients with a wide range of malignancies. Although our initial solid tumor programs are autologous, we are developing T cell engineering technologies and in- house manufacturing capabilities to transition our therapeutic TCRs to alternative modalities allogeneic therapies based on T cells derived from healthy donors or induced pluripotent stem cells. We are also exploring additional next generation technologies, such as in vivo T cell engineering, to further advance our T cell engineering capabilities. • Opportunistically pursue strategic partnerships and collaborations to maximize the full potential of our platform. Our platform represents a powerful tool to identify targets and TCRs in therapeutic areas outside of oncology, such as autoimmune disorders and infectious diseases and infectious disease. We intend to seek strategic partners with proven clinical development and commercialization capabilities for certain targets and / or assets that do not overlap with our internal programs or our core focus. To date, we have a research collaboration and license agreement with Novartis Amgen to identify the novel cancer antigens from the recognized by T cells of in patients with Crohn’s disease a specific type of cancer. Under Novartis has the option to license and develop therapies for up to three- the terms of the agreement discovered targets. Should Novartis license a target, we are TScan received a \$ 30 million upfront payment and is eligible for a to earn success- based milestone payment payments of over \$ 10- 500 million per target, based upon the achievement of certain development and commercial milestones as well as future milestones and tiered single- digit royalties- royalty payments on net sales of products development from the collaboration. Amgen will evaluate a variety of modalities to create therapeutics based on targets discovered by TScan and will retain all global development and commercial rights to such therapeutics. We have also expanded our target discovery capabilities to include both CD8 and CD4 T cell target discovery by engineering our platform to include class II antigen presentation. This capability allows for us to expand discovery efforts into T- cell mediated autoimmune diseases- disorders that have a strong

Major Histocompatibility Complexes, or MHC, class II linkage. We intend to leverage this new capability to identify the pathogenic autoantigens driving T- cell mediated autoimmune **diseases-disorders**. Background on T Cell Therapies The human immune system constantly provides a natural and highly effective defense against cancer, which only forms when tumor cells find a way to evade the immune system. The treatment of cancer was revolutionized over a decade ago with the advent of immunotherapy – therapeutic approaches designed to re- enable or re- direct immune cells to recognize and fight cancer. Over the past 10 years, a suite of immuno- oncology drugs has been approved and adopted as part of routine clinical practice. Successes in immuno- oncology came initially from the approval of immune checkpoint inhibitors and more recently from the development of cellular therapies, such as CAR- T and TIL therapies. These therapies all harness the power of cytotoxic T cells in fighting both hematologic malignancies and solid tumors. Although these therapies have demonstrated compelling efficacy, they are only effective in a subset of patients. To address a broader patient population, we believe additional T cell- based approaches are needed that more closely mimic the way the immune system recognizes and fights cancer in patients who are responding to immunotherapy. Overview of T Cell Biology T cells are an essential component of the adaptive immune system and provide protection against cancer, infection, and autoimmune **disease-disorders**. T cells are classically divided into two primary types of activating cells: helper T cells and cytotoxic T cells. Helper T cells, which express the CD4 co- receptor, function by providing signals to other immune cells for activation and recruitment. Cytotoxic T cells, which express the CD8 co- receptor, function by killing any cells in the human body that are expressing unnatural proteins, including proteins that are not expressed in normal tissue, proteins that arise from mutated genes, or proteins derived from pathogens. By definition, tumor cells are abnormal and make a wide variety of unnatural proteins. T cells are activated and exert their helper or cytotoxic function when their **T-cell receptors, or-TCRs** , recognize antigens displayed on the surface of malignant or infected cells. Virtually every cell in the body has a mechanism for displaying on its surface a sampling of every protein that is being made by the cell. This includes all normal proteins as well as aberrant proteins if the cell is cancerous or proteins from pathogens if the cell has been infected. Cellular proteins are broken down into short fragments, or peptides, by the proteasome, and these peptides are loaded into **Major Histocompatibility Complexes, or- MHCs** , to be displayed on the outside of the cell. These peptide / MHC complexes are recognized by TCRs on cytotoxic CD8 T cells, as shown in the graphic below. Because the TCR recognizes both the peptide and the MHC, a TCR only functions correctly when both the peptide and the correct MHC are present. TCRs on Cytotoxic CD8 T Cells Recognize the Peptide / MHC Complexes of Tumor Cells MHC proteins, which present different peptides to the human immune system, are highly variable among people. An individual’ s MHC proteins are determined by their HLA type. Although there are many different HLA types, some are quite common. For example, 42 % of individuals in the **United States-U. S.** are positive for the HLA- A * 02: 01 allele, or variant. TCRs are often referred to as “ HLA- restricted ” because they are only able to interact with specific HLA types. For this reason, TCR- **Ts** **T therapy harnesses- harness** the specificity of the TCR- peptide- MHC interaction to selectively target tumor cells. Current Approaches to T Cell Therapy Multiple approaches are being explored to develop effective T cell- based therapies for the treatment of cancer. One approach is to isolate naturally occurring T cells from a patient’ s tumor, referred to as **tumor-infiltrating lymphocytes, or-TILs**, expand and activate those cells ex vivo, and then return them to the patient via intravenous infusion. Although the targets of these T cells are not known, it is presumed that T cells isolated from a tumor are enriched in T cells directed against cancer cells. This approach, however, depends on the anti- cancer T cells present in the patient. If the patient’ s TILs do not have appropriate anti- cancer specificities or if their anti- cancer TILs cannot be adequately expanded ex vivo, the therapy is unlikely to be effective. A different approach that has proven effective in certain hematological malignancies is to identify targets that are highly expressed on the surface of tumor cells, such as CD19. Antibody fragments that recognize these targets are used to create an artificial construct that links the antibody to key signaling elements required for T cell activation. The resulting **chimeric antigen receptor, or-CAR** , is incorporated genetically into a patient’ s T cells, thereby redirecting those cells to recognize and fight the patient’ s cancer. Although CAR- T therapies have been highly effective in certain tumor types, leading to multiple approved products, the benefit of these therapies and the addressable cancer indications have been limited by several factors. First, it is likely that there is a relatively limited set of truly tumor- specific cell surface antigens. In general, most antigens expressed on the surface of tumor cells are also expressed on normal cells, resulting in therapies that, even if effective, have a narrow therapeutic window and are vulnerable to potentially life- threatening toxicities. Second, CAR- T cells rely on antibody fragments that recognize cell- surface proteins, precluding intracellular proteins as potential targets. Third, CAR- T therapies generally do not efficiently penetrate solid tumors, which to date has limited their applicability to hematologic malignancies. In contrast to CAR- T therapies, naturally occurring TCRs offer two important benefits compared to antibody- containing artificial receptors. First, TCRs are the natural receptors used by the T cell to recognize foreign antigens. As such, they are optimized to stimulate the T cell appropriately when they engage their targets on a tumor cell. An appropriately stimulated T cell will not only kill the tumor cell, but also produce cytokines that stimulate other immune cells and make copies of itself, or proliferate, to further augment the immune response. Balancing all the cellular responses of a T cell is something that has been finely tuned over millions of years of evolution and is best mediated by naturally occurring TCRs, rather than by artificial constructs. Second, TCRs can recognize a much broader set of antigens, including peptides derived from both cell surface and intracellular proteins, whereas CARs are restricted to recognizing only cell surface proteins. MHC- I peptides are predominantly derived from intracellular proteins rather than extracellular proteins, which dramatically increases the universe of potential cancer- specific antigens that can be recognized by TCRs compared to CARs. We believe TCR- T therapy combines the benefits of TIL and CAR- T therapies while uniquely addressing their key limitations, as shown below. Reprogramming T cells with proven, highly effective TCRs **has the potential to** comprehensively **treats- treat** all cancer patients The development of TCR- **Ts** **T therapy** requires three key prerequisites: (i) an effective anti- cancer TCR; (ii) knowledge of the precise peptide antigen that is recognized by the TCR; and (iii) confirmation that the TCR does not recognize problematic off- targets. Each of these prerequisites is technically challenging. Historically, targets of anti- cancer T cell clones were identified through a manual and

labor-intensive process, and the identification of each target was often a multi-year project. As a result, only a few dozen targets have been identified to date and most clinical development efforts are focused on a short list of the most promising targets. Two key shortcomings in the TCR field remain: **Low** response rates, and limited duration of response. These are **in part** related to solid tumors being heterogeneous, and **to** poor persistence of engineered T cells in patients. We believe we can overcome these known issues by adding enhancements to our product candidates, such as the addition of CD8 α / β to improve persistence compared to CD8 α alone. We are also co-introducing DN-TGF β R2, which is designed to overcome immunosuppression from TGF β in the tumor microenvironment. Our Approach Our approach is based on the central premise that we can learn from patients who are winning their fight against cancer in order to treat those who are not. Using our proprietary platform technologies, we are analyzing the T cells of cancer patients with exceptional responses to immunotherapy to discover clinically relevant targets and TCRs. We are **building-expanding** the ImmunoBank with the goal of delivering customized multiplexed TCR-T therapy to a wide range of patients with cancers. Learning When a patient responds to an immunotherapy drug such as an immune checkpoint inhibitor, their tumor shrinks because T cells in their tumor become activated and drive an anti-tumor cytotoxic response. The TCRs of their T cells recognize tumor-specific antigens on tumor cells and signal the T cell to kill the cancer cells. Our approach starts with isolating clinically active anti-cancer T cells from tumor samples of patients who are responding to immunotherapy agents. We then use our proprietary TargetScan technology to determine the precise targets being recognized by their TCRs. This provides us with a novel TCR / target pair that can be developed into a TCR-T therapy candidate. The advantage of our approach is that when we identify a new target, we know the target is immunologically relevant – the human immune system has already used that target to recognize and fight cancer. Furthermore, we have already identified a TCR that recognizes the target and, importantly, is associated with a meaningful clinical response in a patient. ~~This approach was highlighted in the peer-reviewed journal Cell in 2019.~~ To de-risk clinical development of the TCR, we use our SafetyScan technology to scan across every peptide sequence in the entire human proteome with the goal of ensuring that it does not have any problematic off-target effects. We then select TCRs that are highly active with no apparent problematic off-target effects to be added to the ImmunoBank. In addition to discovering novel TCR / target pairs, we are leveraging our proprietary ReceptorScan technology to identify highly active TCRs against previously identified and clinically validated targets. This approach was featured in the peer-reviewed journal Cell in 2022. Once we identify these highly active TCRs, we use our SafetyScan technology to reduce the risk that they exhibit problematic off-target effects, which de-risks their subsequent clinical development. The diagram below illustrates our proprietary discovery process where therapeutic TCR candidates are discovered using either TargetScan or ReceptorScan and those that we characterize as the best TCRs after screening with SafetyScan are added to the ImmunoBank. Our Proprietary Target and TCR Discovery Process

Treating Our discovery process enables us to build and expand the ImmunoBank with what we believe represents the most active TCRs isolated from a large group of diverse patients who are responding to immunotherapy. We are developing TCR-Ts T therapies that use these clinically relevant TCRs to reprogram the T cells of patients who do not spontaneously generate effective anti-cancer T cells and thus do not respond to immunotherapy. Such patients will first have their tumors undergo HLA typing and testing for the presence of tumor-specific targets. Next, to manufacture engineered T cells, white blood cells will be obtained from either the patient or a healthy donor using a procedure called leukapheresis. We will then transport these white blood cells to our in-house manufacturing facility, where we isolate the T cells and genetically engineer them using TCR sequences from the ImmunoBank. We believe the continued expansion and diversification of the ImmunoBank will enable us to deliver customized multiplexed TCR-T **therapy therapies** to **more** patients, where each patient's T cells are engineered with multiple TCRs that are matched to their specific tumor and HLA type. For example, if a patient's tumor expresses high levels of a particular cancer target, their T cells will be reprogrammed with a TCR that recognizes that particular cancer target. The FDA's clearance of our T-Plex IND **application** for the simultaneous **combination-administration** of different TCRs, as well as secondary **INDs- IND applications** for the first **two-six** TCRs in our solid tumor program, allows us to rapidly and efficiently expand the ImmunoBank and enables us to work toward our goal of bringing customized, multiplexed therapies to patients. Once the T cells are engineered with a combination of the most relevant TCRs, they will be transported back to the **hospital treatment facility** and reintroduced into the patient by intravenous infusion. Following the infusion, the engineered T cells, which are designed to recognize multiple targets expressed by the patient's tumor, will proliferate in vivo and mount an anti-cancer immune response. Our patient treatment and manufacturing process is summarized in the graphic below. Our Patient Treatment and Manufacturing Process

Key Features of Our Approach We believe there are three key advantages to our approach:

- Our TCR- **Ts are based on highly active TCRs that are clinically relevant. Many other approaches to T cell therapies therapy rely on specifically expanding T cells that are already present in the patient. Our platform analyzes anti-cancer T cells from a wide variety of patients who are responding to immunotherapy in order to find the most active and clinically relevant TCRs against each target. We believe that we can develop TCR-Ts for a wide range of patients, including those who do not have T cells that efficiently recognize their cancers.**
- Our TCR- **Ts** are designed to be used in combination with each other. We are **building-expanding** the ImmunoBank of TCRs to allow for multiplexed TCR-T therapy, which has the potential to address the heterogeneous nature of solid tumors and to prevent resistance developing due to loss of a single target. We believe this approach may allow us to overcome the limitations and challenges of TCR-T **therapy** development to date. We **plan-continue** to **populate-prioritize expanding** the ImmunoBank with TCRs for multiple targets as well as multiple common HLA types for each target, thus helping us to overcome the key solid tumor resistance mechanisms of target loss as well as HLA loss. As the ImmunoBank is populated with more TCRs, we expect that patient eligibility will expand, as will our target market opportunities.
- Our approach is expandable. The ImmunoBank has the flexibility to be used with new and optimized methods of T cell engineering that we may develop over time. We **are-building-have built** the ImmunoBank to be compatible with both autologous and allogeneic engineering technologies in order to potentially transition to generating off-the-shelf, allogeneic T cells that have been pre-engineered with our TCRs for direct administration to patients.

Our Platform Our proprietary platform is designed to: (i) discover anti- cancer TCRs from patients with exceptional responses to immunotherapy; (ii) determine novel targets of clinically relevant TCRs; (iii) discover novel TCRs that recognize clinically validated targets; (iv) identify off- ~~targets-~~ **target interactions** of TCRs to eliminate candidates that could potentially pose a safety risk; (v) multiplex treatments through inclusion of clinically relevant targets with HLA type to customize treatments and (vi) manufacture TCR- ~~Ts T therapies~~ efficiently and consistently without the use of viral vectors using T- Integrate. The central elements of our platform that differentiate us from other cell therapy companies are our proprietary platform technologies: TargetScan, ReceptorScan, SafetyScan, the ImmunoBank and T- Integrate. TargetScan — Identification of Novel Targets of Clinically Active TCRs At the core of our proprietary platform is our TargetScan technology that enables us to identify the natural target of a TCR using an unbiased, genome- wide, high- throughput screen. We have developed this technology to be extremely versatile and applicable across multiple therapeutic areas, including cancer, autoimmune disorders, and infectious diseases. It can be applied to virtually any TCR that plays a role in the cause or prevention of disease. To identify the target of a clinically active TCR found in the T cells of a patient responding to immunotherapy, we mix T cells expressing that TCR with a genome- wide library of target cells where every cell in the library expresses a different protein fragment. In each target cell, the protein fragment is processed naturally by the proteasome or immunoproteasome and the resulting peptides are displayed on cell- surface MHC proteins. If a T cell recognizes the peptide- MHC complex on a target cell, it attempts to kill the target cell, thereby activating a proprietary fluorescent reporter in the target cell. By isolating fluorescent target cells and sequencing their expression cassettes, TargetScan reveals the natural target (s) of the T cell, as shown below. This technology was published as a feature article in Cell in 2019. Overview of Our Proprietary TargetScan Technology Central to this technology is the library of protein fragments used for any given TargetScan screen. Our proprietary libraries comprise hundreds of thousands of specific sequences that collectively include most or all of the targets that a TCR could potentially recognize. For example, our current Oncology Target Discovery Library (version 3. 0) comprises **over one million of 700, 000** clones, each expressing a unique protein fragment. Collectively, these fragments span every human protein encoded in the human genome, along with all single nucleotide polymorphisms, or SNPs, which are single amino acid variations in naturally occurring proteins, observed at over 1 % frequency in the human population. In addition, the library includes elements that are specific to cancer cells, which are particularly interesting to us as potential targets: common oncogenic driver mutations, cancer / testis antigens, human endogenous retroviruses, or HERVs, and a large collection of sequences that are not translated in normal tissue but frequently translated in human cancers. We constructed our libraries using a tiling pattern of overlapping fragments to provide complete and redundant coverage of every targeted sequence. Our Oncology Target Discovery Library allows us to precisely identify the novel targets recognized by TCRs from patients who are responding to immunotherapy. In addition, because the library comprehensively covers every non- mutated human protein sequence, we are also able to fully characterize all potential off- target interactions for any given TCR, which we believe will help us reduce the risk and enhance the potential safety profile of our TCR- T therapy candidates before we advance them to clinical development. Furthermore, we can use our screen for any HLA type, enabling target discovery across a wide range of patient demographics. SafetyScan — Elimination of Off- Target Activity SafetyScan is designed to identify potential off- ~~targets-~~ **target interactions** of a TCR and eliminate those TCR candidates that cross- react with proteins expressed at high levels in critical organs. We believe this will allow us to reduce the risk and enhance the potential safety profile of our TCR- T ~~therapy~~ candidates early in development before we initiate clinical trials. The ability to identify problematic off- ~~targets-~~ **target interactions** is critical as TCR- ~~Ts T therapies~~ engineered with TCRs that recognize off- targets expressed at high levels in critical organs could cause toxicities, thereby limiting their therapeutic potential. We use SafetyScan to screen affinity- enhanced versions of TCRs. Affinity enhancement is a process by which a naturally occurring TCR is mutated in order to generate a more potent therapeutic construct. One such affinity- enhanced TCR that we screened had previously entered clinical trials with a different sponsor, but human testing of the TCR was halted abruptly because two patients treated with T cells engineered to express this affinity- enhanced TCR died of acute cardiac failure within five days of T cell administration. Subsequent studies revealed that this TCR recognized an off- target derived from the muscle protein **Titin-titin**, which is abundantly expressed in cardiac tissue. When we screened this same affinity- enhanced TCR using our SafetyScan technology, we identified a variety of potential additional off- targets which were not seen in our screen of the natural TCR, including the protein **Titin-titin**. This experiment demonstrates why we believe that our SafetyScan technology provides a significant competitive advantage, because it enables us to rapidly and efficiently eliminate from our preclinical pipeline TCRs that are identified as recognizing potentially problematic off- targets. Importantly, this includes off- targets that may not be identified through standard bioinformatics or in- vitro tissue assays. We believe that SafetyScan thereby has the potential to enable us to decrease the risk of encountering unexpected toxicities in our clinical trials by providing a genome- wide understanding of off- target effects. Using our TargetScan technology, we have identified **about 100-approximately 200** novel antigens as targets of tumor infiltrating T cells from patients who are responding to immunotherapy. We believe this provides us with a competitive advantage, because not only are we among the first to identify these targets as tumor- specific antigens, but ~~also~~ we have **also** already identified highly active TCRs that recognize these targets. ReceptorScan identifies **ultra-high-ultra- high** affinity, naturally occurring TCRs with low risk of off- target effects T- Integrate — Genetic Engineering of T Cells Using Transposons Cell therapy manufacturing is highly complex, and associated challenges have led to significant delays or failures in the development of many cell therapies. To enable the rapid, cost- effective, and consistent manufacturing **for a variety** of **selected** TCRs, we have developed a non- viral vector delivery system that we refer to as T- Integrate. Our manufacturing platform enables us to introduce any of the TCRs from the ImmunoBank, along with additional genetic elements such as CD8 that further augment T cell function, into the genomes of patient- or donor- derived T cells. Genetically engineering a T cell requires two steps: (1) delivering DNA encoding the TCR into the nucleus of a T cell and (2) integrating that DNA into the genome of the T cell. These two steps are often accomplished through the use of retroviral vectors, such as lentivirus, by packaging RNA encoding the TCR into lentiviral particles, which are then used to infect

T cells. Although effective, manufacturing lentiviral particles is time- consuming, costly, and often highly variable. In addition, each new TCR requires extensive process development, as the TCR sequence affects the efficiency with which it is packaged into the lentivirus. As a more efficient and reproducible alternative to lentivirus, we have developed T- Integrate to genetically engineer T cells using a transposon / transposase system, as shown in the graphic below. In this system, DNA encoding the TCR is manufactured as a Nanoplasmid™ and enables DNA delivery using a smaller plasmid footprint. The Nanoplasmid, together with an mRNA sequence encoding a transposase enzyme, is introduced into the T cell by electroporation. After the T cell translates the mRNA into protein, the transposase enzyme inserts the TCR sequence from the Nanoplasmid into the genome of the T cell. This system is highly reproducible, as the only required components are a Nanoplasmid, which is different for each TCR product, and an mRNA, which is constant for all TCR products. Unlike lentivirus, both of these components are routinely manufactured in a cost- effective manner without the need for extensive process development. We believe our manufacturing platform will enable us to efficiently develop and manufacture many different TCR- **Ts T therapies**, allowing us to deliver customized multiplexed therapy to patients with cancer. **We** As of February 28, 2023, we have successfully manufactured TSC- 100 and TSC- 101 **and but have not yet** dosed patients in our hematological-- **hematologic** malignancies program. The FDA has cleared **three seven INDs-- IND applications** for our solid tumor program, including our primary IND **application**, T- Plex **, which supports the simultaneous use administration** of multiple TCRs to create customized --multiplexed TCR- T **cell therapy** candidates, as well as **INDs-- IND applications** for TSC- **200- A0201 (HPV16, HLA- A * 02: 01), TSC- 201- B0702 (MAGE- C2, HLA- B * 07: 02), TSC- 203- A0201 (PRAME, HLA- A * 02: 01), TSC- 204- A0201 and (MAGE- A1, HLA- A * 02: 01), TSC- 204- C0702 (MAGE- A1, HLA- C * 07: 02), and TSC- 204- A0101 (MAGE- A1, HLA- A * 01: 01)**. Our T- Integrate Manufacturing Platform Our transposon vector includes both the beta and alpha chains of the TCR under the control of a strong promoter. This is designed to ensure that high levels of the TCR are produced on the surface of the T cells and that the TCRs that are normally expressed in the patient **'s** or donor' s T cells, or the ' endogenous' TCRs, are suppressed. We have also introduced specific alterations in the constant region of the TCR to further augment its stability. In addition to the TCR, our transposon construct includes genes encoding the alpha and beta chains of the cell- surface protein CD8. CD8 forms a complex with the TCR and is necessary for the TCR to recognize its target on tumor cells. Including the CD8 co- receptor in our construct enables us to genetically reprogram both major types of T cells: cytotoxic T cells that naturally make their own CD8 **,** and helper T cells that do not make CD8. Our final TCR- **Ts T therapies** are a mixture of both cytotoxic and helper T cells that have been reprogrammed to recognize and eliminate tumor cells expressing the relevant targets. We also included a short peptide tag at the beginning of **CD8- CD8α alpha** in our construct. This tag does not interfere with the function of **CD8- CD8α alpha** but provides a way to easily purify the engineered T cells during our manufacturing process. We **are also plan to further enhance enhancing** our T cell therapies with the addition of DN- TGFβRII to overcome the immunosuppressive tumor microenvironment. An illustration of the construct of our TCR- **Ts T therapies** is shown below. Construct of our TCR- **Ts T Therapies** Another important advantage of T- Integrate, our manufacturing platform, is that its greater carrying capacity than the commonly used lentiviral approach enables us to introduce additional genes that augment T cell function along with the gene that encodes the TCR itself. As our programs advance, we intend to introduce additional elements to our products with the goal of further improving their performance in the solid tumor setting, including features designed to increase the penetration of our T cells into solid tumors, with the aim of keeping our T cells active for a longer time and rendering our T cells more impervious to the hostile tumor microenvironment. **Our Programs With our differentiated platform as our foundation, we are building a three- pillar research and development strategy to create transformational TCR- T therapies for patients, as shown below.** We are developing our hematologic malignancies program to treat patients with **non- B cell malignancies (AML, MDS, or ALL)** who are undergoing allogeneic HCT. In the first phase of our clinical development strategy, we are initially focusing on well- recognized cancer targets that have been discovered in patients with exceptional responses to HCT- associated immunotherapy, including HA- 1 and HA- 2. Our program is based on the well- established observation that patients who are mismatched with their donors for minor histocompatibility antigens such as HA- 1 or HA- 2, and naturally mount a T cell response against those antigens, show significantly lower relapse rates following HCT. By developing TSC- 100 and TSC- 101, TScan aims to recreate this natural graft versus leukemia response **in order** to prevent relapse in patients undergoing HCT. Minor histocompatibility antigens like HA- 1 and HA- 2 are distinct from other cancer- associated antigens such as WT1 previously targeted by TCR- **Ts T therapies** in hematologic malignancies. As shown below, cancer- associated antigens like WT1 have low and heterogenous expression and were previously selected so that normal blood cells in the patient would be relatively spared. WT1- targeted TCR- **Ts T therapies** proved to have relatively poor efficacy in patients with AML, potentially due to the rapid emergence of resistant tumor cells that had lacked WT1 expression and thus escaped killing by engineered T cells. HA- 1 and HA- 2 in contrast have high and homogenous expression (see below) **,** making it less likely for tumors cells to escape due to low antigen expression. While HA- 1 and HA- 2 are also expressed in normal blood cells, treating HA- 1 / HA- 2 positive patients who receive stem cell transplantation from donors who are negative for HA- 1 / HA- 2, ensures that the engineered T cells selectively eliminate all the patient' s blood cells, **cancerous malignant, pre- malignant** or normal, while sparing donor- derived normal blood cells. This strategy therefore enables high levels of anti- cancer efficacy with what we believe to be less risk of life- threatening toxicities to normal cells. We are conducting clinical trials of our lead TCR- T **therapy** candidates, TSC- 100 and TSC- 101, in parallel, with patients **to be** enrolled in treatment arms based on their genotype, as shown below. Patients who are positive for the target antigen, HA- 1 or HA- 2, as well as the HLA- A * 02: 01 allele, which is the HLA type required to display HA- 1 and HA- 2 on the cell surface for recognition by a T cell, will be eligible for enrollment. Furthermore, eligible patients will require donors who are negative for either the target antigen or the HLA- A * 02: 01 allele. Our Clinical Development Strategy for Multiple TCR- T **Therapies- Candidates** Background on Hematologic Malignancies HCT has become the standard of care for many hematologic malignancies. When a patient with leukemia undergoes HCT, they start by receiving a conditioning regimen of high dose chemotherapy with or without radiation. This regimen is intended to kill both the patient' s

leukemia cells as well as their native blood cells and blood cell precursors, including hematopoietic stem cells in their bone marrow. The patient then receives hematopoietic stem cells from an HLA- matched donor. The stem cells engraft in their bone marrow and start to repopulate their body with new blood cells, which are now genetically identical to the donor. HCT has demonstrated the rare opportunity in cancer treatment to generate long- term remissions or cures. For example, patients with acute myeloid leukemia, or AML, who receive HCT have a five- year post- transplant survival rate of 44 up to 40 %. Approximately 7.8, 000 allogeneic HCT procedures are performed yearly in the United States U. S., primarily in patients with AML, MDS, or ALL. Approximately 7, 500 allogeneic HCT procedures are performed yearly in the U. S. in patients with AML, MDS, or ALL. As a curative therapy for many hematologic malignancies, use of HCT has been steadily increasing over the last two decades, as shown below, with increased use driven largely by increasing donor qualification, an increase in disease prevalence due to aging populations, and improved conditioning regimens permitting broader use in older and frailer patient segments. In addition, newer, more effective leukemia therapies continue to drive an increasing use of HCT in patients who previously failed to achieve proper remission prior to transplant. While the approval of CAR- T therapies has significantly impacted the treatment of B cell malignancies over the last decade, HCT in non- B cell malignancies is anticipated to remain the standard of care for patients. An example of the limitations associated with CAR- T therapy is the difficulty differentiating tumor from normal cells of as seen with CD19- targeted CAR- T therapies. CD19 is a target highly expressed on the surface of tumor cells, as well as and is also expressed on normal B cells, which are also eliminated by CD19 targeted CAR- T cells. While loss of B cells does not generally lead to serious complications, toxicity on other normal myeloid blood cell types such as neutrophils would cause a life- threatening complication called febrile neutropenia in which bacterial infections occur due to the loss of neutrophils. This is one reason why CAR- T therapies cannot be used in non- B cell hematologic malignancies such as myeloid leukemias and HCT remains the standard of care for those patients. The Number of Allogeneic HCT Procedures in the U. S. Continues to Rise However, despite the increasing use of HCT and the resulting clinical benefits or cures, approximately 40 % of the patients who receive HCT relapse, at which point there are limited treatment options, and the prognosis is very poor. Clinical observations have shown that if the T cells of the donor recognize certain minor histocompatibility antigens, or miHAs, in the patient' s leukemia cells, such as proteins that have single amino acid differences between the patient and the donor, the T cells of the donor drive a specific graft vs. leukemia, or GvL, effect, whereby the engrafted donor T cells detect remaining leukemia as foreign and eliminate the remaining disease. As a result, the patient often experiences a long- term remission from their cancer, or even a complete cure. If the miHAs are also expressed in non- hematopoietic tissues, the patient may develop graft vs. host disease, or GvHD, but if the miHAs are only expressed in blood cells, a specific GvL effect is observed without an increase in GvHD. Our hematologic malignancies program is focused on targeting miHAs that are exclusively expressed in hematopoietic cells in order to induce the GvL effect while potentially mitigating the risk of GvHD. TSC- 100 is an allogeneic, donor derived TCR- T therapy candidate directed at eliminating all native blood cells, including residual cancer cells, in HA- 1- positive and HLA- A * 02: 01- positive patients with hematologic malignancies who undergo HCT using a donor who is either HA- 1- negative or HLA- A * 02: 01- negative. Using ReceptorScan, we screened over a hundred million CD8 T cells and identified and assessed hundreds of highly active TCRs that recognize the HA- 1 antigen. We selected TCR- 100a based on its superior affinity, cytotoxic activity, and specificity compared to the others. TSC- 100 is designed to elicit an anti- tumor response in patients by targeting HA- 1, which is present on malignant and normal blood cells of HA- 1- positive patients but not on any of the new, donor- derived blood cells they receive from a donor who is either HA- 1- negative or HLA- A * 02: 01- negative. We believe that donor T cells specifically engineered to express TCR- 100a will generate an anti- tumor effect in patients, leading to a reduction in relapse rates and an increase in long- term survival. HA- 1 was one of the first miHAs to be discovered in a patient undergoing HCT. HA- 1 is a peptide antigen derived from the protein ARHGAP45, which is an intracellular protein expressed at high levels in all blood cells but not in any other tissue. ARHGAP45 comes in two forms. In HA- 1- positive individuals, the peptide has the sequence VLHDDLLEA and, if the individual has the HLA type A * 02: 01, the antigen is efficiently displayed on the surface of blood cells. In HA- 1- negative individuals, the peptide has the sequence VLRDDLLEA, and the HA- 1 antigen is not displayed. Approximately 60 % of people have the VLHDDLLEA sequence and approximately 42 % of people in the United States U. S. have the HLA type A * 02: 01, which means that approximately 25 % of individuals in the United States U. S. are HA- 1- positive with the specific HLA type required for antigen expression. Studies of patients receiving HCT have shown that in cases where the T cells of an HA- 1- negative donor naturally develop a response to HA- 1 in an HA- 1- positive patient, the T cells mediate a specific GvL effect, and the patient often experiences a long- term remission. TSC- 100 is based on this clinical observation and is designed to specifically cause this GvL effect in patients receiving HCT. We are developing TSC- 100 as a treatment for patients with cancer who are HA- 1- positive and have been deemed eligible for HCT. For each patient, a healthy donor who is HA- 1- negative or HLA- A * 02: 01- negative will be identified. Hematopoietic stem cells isolated from that donor will be used as the source of transplant material. In parallel, T cells isolated from the same donor will be genetically engineered to recognize HA- 1. Once engraftment of donor stem cells is established in the patient, TSC- 100 will be infused into the patient with the goal of eliciting a highly specific anti- tumor effect. The engineered donor T cells are designed to recognize and eliminate all of the patient' s native blood cells, including residual leukemia cells, which are HA- 1- positive, thereby preventing relapse and potentially promoting complete cures. Because the patient' s new healthy blood cells are derived from the donor and are therefore either HA- 1- negative or HLA- A * 02: 01- negative, we believe that TSC- 100 should have minimal toxic side effects. A summary of the treatment paradigm for TSC- 100 is illustrated below. TSC- 100 Treatment Paradigm Because people inherit two copies of every chromosome, one from their mother and one from their father, everyone has two copies of the ARHGAP45 gene. HA- 1- positive patients can therefore be either homozygous for HA- 1 (/), with both genes encoding the HA- 1- positive peptide (VLHDDLLEA), or heterozygous for HA- 1 (-/), with one gene encoding the HA- 1- positive peptide and the other encoding the HA- 1- negative peptide (VLRDDLLEA). To ensure that TSC- 100 can is able to effectively

eliminate healthy blood cells and leukemia cells that are either homozygous HA- 1- positive (/) or heterozygous HA- 1- positive (/ -), we assessed the activity of TSC- 100 against blood cells derived from a variety of healthy donors and patients with AML and ALL. In preclinical studies, TSC- 100 eliminated both homozygous and heterozygous HA- 1- positive healthy blood cells and leukemia cells. It is known in the cell therapy field that TCRs which exhibit off- target effects can potentially cause toxicity. **To** ~~In order to~~ reduce the potential for TCR- 100a to exhibit problematic off- target effects, we used SafetyScan to comprehensively scan for any other potential targets recognized by TCR- 100a. In the screen, all three protein fragments in the library that contain the HA- 1- positive peptide antigen were strongly enriched, and no significant off- target interactions were observed. In contrast, some of the other HA- 1- specific TCRs identified by ReceptorScan did exhibit off- target effects, highlighting our ability to select candidates that we believe have favorable risk / benefit profiles. **Like Similar to** TSC- 100, TSC- 101 is an allogeneic **, donor derived** TCR- T ~~therapy~~ candidate directed at eliminating residual cancer cells in HA- 2- positive and HLA- A * 02: 01- positive patients with hematologic malignancies who undergo HCT using a donor who is either HA- 2- negative or HLA- A * 02: 01- negative. HA- 2, which is derived from the protein MYO1G, is another miHA that has been identified to be clinically relevant. In patients who naturally develop HA- 2- specific T cells, a GvL effect has been observed and these patients experience long- term remissions. Using ReceptorScan, we have identified a highly active TCR, which we refer to as TCR- 101a, that recognizes HA- 2. ~~In the fourth quarter of 2021, we filed an IND for TSC- 101. The FDA cleared our IND for TSC- 101, enabling us to move forward with Phase 1 clinical development.~~ Unlike HA- 1, the HA- 2 antigen is highly prevalent, with approximately 95 % of individuals in the **United States U. S.** being HA- 2- positive. However, as with HA- 1, a specific HLA type, HLA- A * 02: 01, which is present in approximately 42 % of individuals in the **United States U. S.**, is required to display the HA- 2 antigen on the cell surface for recognition by a T cell. As a result, approximately 40 % of HCT patients would be positive for both HA- 2 and HLA- A * 02: 01 and therefore be eligible for treatment with TSC- 101 using a donor who is negative for HLA- A * 02: 01, regardless of whether the donor is HA- 2- positive or HA- 2- negative. Such donors are straightforward to identify and should be available to most patients who undergo half- matched, or haploidentical, transplantation using family members as donors, as patients typically have between two and three potential haploidentical donors. **Like Similar to** TCR - 100a, we used ReceptorScan to identify TCR - 101a. We screened approximately 237 million CD8 cells from five healthy HA- 2 negative donors and identified approximately 1, 302 natural TCRs that recognize HA- 2. These were then narrowed down to 15 TCRs with the highest surface expression and greatest affinity for the HA- 2 peptide. We further evaluated the top five TCRs for off- target cross- reactivity against the entire human proteome using SafetyScan, identifying TCR- ~~101~~ **101a** as the most active TCR with the lowest off- target activity and cleanest cross- reactivity profile against 108 other HLA alleles. Finally, TSC- 101, our TCR- T ~~therapy~~ candidate which is T cells manufactured to express TCR- ~~101~~ **101a**, was tested on a panel of normal cell types representing all vital organs and did not recognize any normal non- hematologic cell type. In contrast, TSC- 101 demonstrated efficient cell killing of both normal and malignant primary hematologic samples confirming a high degree of selectivity for hematologic cells. The discovery of TCR- ~~101~~ **101a** was presented at the 63rd American Society of Hematology Annual Meeting and Exposition, in December 2021. Clinical Development Plan for Our Hematologic Malignancies Program Background on Types of HCT Patients with acute leukemias who undergo allogeneic HCT have heterogeneous outcomes that are primarily related to two main variables: (i) the intensity or doses of the conditioning regimen they receive prior to the stem cell infusion and (ii) the type of donor who provides the stem cells. High- intensity conditioning regimens are called myeloablative conditioning and **are** associated with higher mortality rates. They are therefore reserved for young and relatively fit patients. Lower- intensity regimens are called reduced- intensity conditioning, or RIC, and **are** better tolerated, but are associated with higher relapse rates. TSC- 100 and TSC- 101 are both designed to substantially reduce relapse rates, and we **are plan to enroll enrolling** patients who are eligible for RIC- based HCT with the goal of improving clinical outcomes for these patients. There are different types of donors who are eligible for allogeneic HCT procedures. Donors who are siblings of the patient and are perfectly matched for eight out of eight HLA alleles are considered the highest priority donor type for patients undergoing allogeneic HCT, but these types of donors are available for less than a third of patients. For **most** the majority of patients, the choice is between an unrelated donor who is perfectly matched for eight out of eight HLA alleles, referred to as a matched unrelated donor, or MUD, or a family member such as a sibling ~~, parent~~ or child who has a half- match with the patient, referred to as a haploidentical donor, or haplo. Historically, haplo donor transplantation was associated with much higher GvHD than MUD ~~transplants~~, but a recent treatment regimen that uses chemotherapy given three days after stem cell infusion called post- transplantation cyclophosphamide, or PTCy, specifically kills immune cells that cause GvHD. As a result, haplo transplants with PTCy have recently achieved equivalent outcomes as MUD transplants and are rapidly increasing in usage in the **United States U. S.** and worldwide. The use of haplos greatly expands the donor pool for patients undergoing HCT and provides patients with the optionality to choose donors who are mismatched on specific HLA types, such as A * 02: 01, as opposed to being mismatched on certain minor antigens, such as HA- 1 or HA- 2. We are developing TSC- 100 and TSC- 101 with a specific focus on patients undergoing haplo donor transplantation with donors who are negative for either the miHA or the specific HLA type. We believe the engineered donor T cells will recognize any residual leukemia cells, which are target- positive, in the patient and prevent relapse with the potential to promote complete cures. Because the patient' s new healthy blood cells are derived from the donor and are therefore either target- negative or not able to express the target, we believe TSC- 100 and TSC- 101 should have minimal toxic side effects. Phase 1 Clinical Trial ~~The We have initiated~~ clinical studies for TSC- 100 and TSC- 101 **are well underway**, within a multi- arm, controlled, Phase 1, **"umbrella 2"** design clinical trial to investigate the safety and efficacy of TSC- 100 and TSC- 101 in patients with ALL, AML, and MDS, that are undergoing HCT following RIC **. We are currently dose escalating both treatment arms and are currently treating patients at the third and final dose level**. Our Phase 1 clinical trial is designed to include measurements of early surrogate markers of efficacy, such as **donor** chimerism, or the percentage of blood cells that are donor- derived, and whether patients continue to have detectable residual leukemia **, referred to as minimal residual disease,**

or MRD, in their post-transplant bone marrow biopsy, both of which are predictors of relapse. As shown in the graphic below, we are also including a control arm, comprising patients who do not meet the HLA or miHA genetic criteria and are treated with standard RIC haplo transplantation alone. Comparisons of both safety and efficacy outcomes with this control arm will potentially enable all patients treated with TSC-100 or TSC-101 to be included as part of the efficacy analysis for the initial Phase 1 trial prior to transitioning the program into a registrational Phase 2 trial towards a future biologics license application, or BLA, filing. Multi-Arm Phase 1 Clinical Trial Design

Initial clinical data In February 2024 we reported updated results on the first 14 patients enrolled in our ongoing Phase 1 hematologic malignancies study, which we presented at the 2024 Tandem Meetings: Transplantation & Cellular Therapy Meetings of the American Society for Transplantation and Cellular Therapy (ASTCT®) and the Center for International Blood and Marrow Transplant Research (CIBMTR®). Eight patients were enrolled in the treatment arms, and six patients were enrolled in the control arm. A total of four patients were treated with TSC-100, one with T-ALL, two with AML, and one with MDS, and four patients were treated with TSC-101, one with TP53-mutated MDS, one with AML and two with B-ALL. In both the TSC-100 and TSC-101 treatment arms, all patients (8/8) achieved complete donor chimerism, associated with a favorable prognosis. One AML patient was MRD-positive following HCT, converted to MRD-negative following treatment with TSC-101, and maintained MRD-negative status, with the most recent measurement at day 180 post-transplant. The six control-arm patients, three with MDS and three with AML, were enrolled and received standard of care consisting of HCT alone. One TP53-mutated MDS control-arm patient evolved with MRD positivity and worsening mixed chimerism, ultimately experiencing disease relapse approximately six months after transplantation and unfortunately succumbed to the relapse approximately nine months after transplant. Additionally, one MDS patient in the control arm had a clinical relapse approximately five months after transplantation, and one MDS patient in the control arm developed worsening mixed chimerism that prompted early termination of immunosuppression resulting in complete donor chimerism. Two of the six patients in the control arm achieved complete donor chimerism following HCT.

Anticipated timeline We have now successfully manufactured filed INDs for TSC-100 and dosed TSC-101 in the fourth quarter of 2021. The FDA has cleared our INDs for TSC-100 and TSC-101, enabling us to move forward with our clinical development plans. We expect to enroll patients in all three both treatment arms in of the Phase 1 umbrella clinical trial for TSC-100 and TSC-101 and plan to report safety and biomarker data mid-year. Additionally Patients have been enrolled up to the third and final dose level in both treatment arms with no dose limiting toxicities thus far, suggesting we expect that we the third and final dose level will reach likely become the recommended Phase 2 dose for TSC-100 and TSC-101 and report further clinical safety and biomarker data for the program by the end of 2023. We expect to open expansion cohorts at this recommended Phase 2 dose level to further characterize safety and evaluate translational and efficacy endpoints in the third quarter of 2024. Additionally, we plan to complete enrollment and report one-year clinical and translational data on initial patients in 2024 and report two-year prevention of relapse data in 2024-2025.

Future market expansion opportunities If TSC-100 and TSC-101 demonstrate the ability to significantly reduce relapse rates after HCT, there could potentially be new opportunities to expand the curative potential of HCT combined with TSC products to greater numbers of patients. Currently, only about 7,000 500 patients with AML, MDS, or ALL undergo HCT per year in the United States-U.S. out of approximately 40-35,000 patients diagnosed each year with AML, MDS and ALL. There are two reasons for this relatively modest rate of transplant utilization use. First, only patients who achieve a clinical complete remission (CR) are referred for HCT since the relapse rates of patients not in CR are considered too high to safely effectively use HCT. If HCT, combined with either TSC products-100 or TSC-101, markedly reduce-reduces relapse rates, patients who do not achieve CR could still possibly undergo HCT and benefit from its curative potential. This market expansion would require a separate clinical trial. Second, while RIC reduced-intensity conditioning has enabled many more elderly and frail patients to undergo transplantation, the chemotherapy and radiation doses used for conditioning are still high and considered too toxic for most patients over the age of 65 or those with underlying comorbidities. This is because the conditioning regimen of HCT is considered the primary modality to for eliminate eliminating residual leukemia cells and reducing doses further would result in greater relapse rates. If however, the relapse rates could be reduced by a treatment with either TSC product-100 or TSC-101 post HCT, however, a clinical trial could test the use of minimal intensity conditioning prior to HCT. If successful, this would further expand the curative potential of HCT combined with TSC-100 or TSC-101 therapy to older, frailer patients. A final market expansion opportunity could occur from the use of either TSC products-100 or TSC-101 as a chemotherapy and radiation-free conditioning regimen for non-malignant diseases such as sickle cell anemia which are currently treated with HCT. Since chemotherapy and radiation are associated with the risk of long-term toxicities such as cancer, heart damage, lung damage and infertility, cellular therapies such as TSC-100 or TSC-101 could reduce those risks and increase the numbers of patients willing to undergo HCT for non-malignant diseases. We are developing a portfolio of autologous TCR-T therapy candidates that are designed to be used in combination with each other to treat and eliminate solid tumors. Our TSC-200-20X series of product candidates are designed to elicit an anti-tumor response in patients by targeting cancer-specific antigens in their tumor cells. Our TCR-T therapy candidates include: (i) either well-recognized cancer targets that have demonstrated anti-tumor activity in clinical trials or novel targets that were identified by TargetScan from the T cells of patients responding to immunotherapy and (ii) naturally occurring TCRs specific to a patient's HLA type that recognize these cancer-specific targets. Such targets are not only commonly shared among patients with the same cancer type, but also frequently expressed in multiple solid tumor types, enabling clinical development across multiple indications. Our six solid tumor TCR-T therapy candidates include a combination of known targets, such as HPV16 for TSC-200, the previously undisclosed target MAGE-A4 for TSC-202, PRAME for TSC-203, and MAGE-A1 for TSC-204, as well as a novel TCR-T therapy targets-target that have has not yet been tested in the clinic, such as MAGE-C2 for TSC-201, TSC-202, and TSC-205. To date, we have We are currently advancing our six solid tumor TCR-T therapy candidates. We received FDA clearance for seven our initial three INDs for the treatment of solid

tumors. These include a primary IND for the entire solid tumor program, which we refer to as T- Plex, which supports the simultaneous use of multiple TCRs to create customized, multiplexed TCR- T cell therapy candidates based on target and HLA expression. The FDA **has** also cleared INDs for TSC- **204-203** - A0201 (**PRAME** and TSC- **204- C0702**, the first two TCRs in the ImmunoBank, targeting MAGE- A1 on HLA types - A * 02: 01 and); TSC- **200- A0201** (HPV16, HLA- A * 02: 01); TSC- **201- B0702** (MAGE- C2, HLA- B * 07: 02); TSC- **204- A0201** (MAGE- A1, HLA- A * 02: 01); TSC- **204- C0702** (MAGE- A1, HLA- C * 07: 02); and TSC- **204- A0101** (MAGE- A1, respectively HLA- A * 01: 01) . We plan to further expand the ImmunoBank by filing INDs for additional TCRs throughout **2023-2024** . In addition to our **six**-lead solid tumor TCR- T **programs** therapy candidates, we have identified about **100-200** novel antigens as targets of tumor infiltrating T cells from patients who are responding to immunotherapy using our TargetScan technology. We are in early stages of analyzing these additional novel antigens and plan to advance those that we believe have the best potential as a TCR- T therapy candidate into preclinical development. We **are building** **have built** the ImmunoBank, a **collection** **repository** of highly active TCRs, to enable multiplexed TCR- T therapy. Our vision is to expand the ImmunoBank with TCRs that recognize diverse targets and are associated with multiple HLA types **in order** to provide a broad array of therapeutic options for patients with various types of solid tumors. For patients with a solid tumor malignancy, we plan to analyze their tumor to determine which targets are expressed at high levels in their **particular** cancer. We will then access the ImmunoBank and select up to three TCRs that match their HLA type and address the most highly expressed targets in their tumor. We will use this set of TCRs to genetically reprogram their T cells to recognize these targets and the resulting engineered T cells will be infused back into the patient **simultaneously** as a multiplexed TCR- T therapy. Our Strategy to Treat Solid Tumors with Multiplexed TCR- T Therapy **Ts T Therapy** for the Treatment of Solid Tumors Immunotherapy has reshaped the treatment of solid tumors by demonstrating that tumor shrinkage, eradication, and long- term durable responses can be obtained by stimulating the patient' s own immune system to attack their cancer cells. Immune checkpoint inhibitors, such as nivolumab or pembrolizumab, work by unleashing anti- cancer T cells that are already present in a patient' s tumor, enabling those T cells to recognize and eliminate their cancer. For patients who respond to checkpoint inhibitors, these agents have been shown to be very effective. However, only a subset of patients responds to checkpoint inhibitors, highlighting the need for T cell- based therapies that can treat those patients who do not respond. Despite their efficacy in only a subset of patients, checkpoint inhibitors have annual sales **well in excess of** **about** \$ 25 billion **in the U. S** . One reason why patients do not respond to current immunotherapy treatments is that they lack T cells with highly active TCRs that recognize cancer- specific antigens in their tumors. By reprogramming the patient' s own T cells to recognize these targets, we believe that we can expand the dramatic responses observed with checkpoint inhibitor therapy to the patients for whom these therapies are ineffective. Our Solution Our solid tumor program is based on the premise that if we can understand how T cells naturally fight cancer, we can use this information to design life- changing TCR- **Ts T therapies** for virtually any patient with cancer. Our discovery process begins with identifying patient T cells that are actively driving their clinical response to immunotherapy. We then use TargetScan to determine the precise targets of these highly active TCRs. Our discovery efforts are initially focused on patients with head and neck cancer who respond to checkpoint inhibitor therapy and patients with melanoma who respond to TIL therapy. These cancers represent tumor types with a high degree of T cell infiltration and strong responses to immunotherapy, which provides us with clinically active T cells from which we can discover novel TCR / target pairs. We have found that targets discovered in one type of cancer are often expressed in other cancers as well, enabling broader clinical development of our TCR- T **therapy** candidates. The tumor types we are focused on also express several known targets that were previously discovered from patient T cells. We are using ReceptorScan to discover highly active TCRs for these previously identified targets to complement the discovery of our novel TCR / target pairs. Finally, the ImmunoBank will allow us to target multiple HLA types to prevent target loss and increase durability of response. Novel Targets Identified from Patients with Head and Neck Cancer One of the ways we identify anti- cancer TCRs is by focusing on T cells that clonally expand in a tumor when the patient responds to checkpoint inhibitor therapy. Some of this work is being performed under collaborative research agreements with various academic institutions. Using single cell sequencing, our collaborators determined the TCR sequences of thousands of T cells in the tumors of patients with head and neck cancer before and after immunotherapy. This analysis also revealed the frequency of each T cell clone in the tumor samples. As an example, if a particular TCR sequence is observed at 0. 05 % frequency in the tumor before the patient receives immunotherapy and then increases to 5 % after the tumor starts to shrink, the T cell has clonally expanded 100- fold and is likely to have played a causal role in driving the patient' s clinical response. Certain TCR sequences are not detectable in the pre- treatment biopsy but are observed at high frequency in the post- treatment tumor. These emerging clones are also potential candidates for driving the patient' s clinical response. An illustrative example of T cell sequencing data from one patient with head and neck cancer who had a complete response to immunotherapy **can be found below** . Clinically Relevant Anti- Cancer T Cells Identified Through T Cell Sequencing Novel Targets Identified from Patients with Melanoma Another approach we use to identify clinically relevant anti- cancer T cells is to analyze T cells from patients with melanoma who respond to TIL therapy. Using single cell sequencing, we determine the TCR sequences of the T cells in the responding patient' s TIL therapy product and focus on the most abundant T cell clones. We have found that TIL therapy products are often dominated by as few as two or three clones, further increasing our confidence that these TCRs played a causal role in fighting the patient' s cancer. To increase the throughput of our discovery efforts, we have used TargetScan in a more directed manner to screen sub- libraries of protein fragments that focus on particular classes of tumor antigens. For example, we built a sub- library that focuses on cancer / testis antigens, or CTAs, which are genes that typically play a role in embryonic development but are not expressed in any adult tissues other than testes. T cells do not infiltrate testes and cells in the testes have very low levels of MHC proteins, making testes an immune- privileged site that will not be targeted by engineered T cells in the context of cell therapy. CTA genes are frequently found to be expressed in tumor cells and often play a role in causing cancer. Several well- recognized targets in development for TCR- T therapy are CTAs, including NY- ESO- 1 and MAGE- A4. We are focused on the discovery of novel

targets within this class of antigens and have built a TargetScan library comprising 40,000 fragments that cover 1,600 CTA genes. Because this library is substantially less complex than our genome-wide Oncology Target Discovery Library, we can screen the TargetScan library with dozens of TCRs simultaneously. For example, we screened 35 TCRs derived from 11 patients with melanoma who received TIL therapy. In a single screen, we identified **three** TCR / target pairs that recognize CTAs, including the antigen target for one of our lead solid tumor product candidates, TSC-201, which we **refer to recently disclosed** as **Target-MAGE-201-C2**, and **TSC-202**, which we **recently disclosed** as **MAGE** well as **two other antigens that have not previously been identified as targets for TCR-A4 T therapy**. TCR and Target Validation Process When we discover novel TCR / target pairs, we first determine if the gene that encodes the target is expressed at high levels in normal tissue. We found that **Target-TSC-201 (MAGE-C2)** is exclusively expressed in testis, which is an immune privileged tissue and, as a result, should not pose a significant safety concern. We also examined how frequently the target is expressed in various solid tumors. In the screen, **Target-MAGE-201-C2** was overexpressed in a high percentage of melanoma tumor samples as well as in several other tumor types, including non-small cell lung cancer, or NSCLC, and head and neck cancer, and cervical cancer. Next, as part of our discovery process, we test if the TCRs discovered with our approach **can are able to kill cancer cells that naturally express the relevant target and specific HLA type**. As shown below on the left, when T cells expressing the TCR that recognizes **Target-MAGE-201-C2** are cultured with melanoma cell lines that naturally express different levels of **Target-MAGE-201-C2**, such as A101D and SKMEL5, the degree to which the T cells get activated correlates with the expression level of **Target-MAGE-201-C2** in the melanoma cells. In addition, the T cells kill melanoma cells expressing high levels of **Target-MAGE-201-C2**, as shown below on the right but do not kill cells that express low levels of **Target-MAGE-201-C2**, which highlights the selectivity of the TCR for **Target-MAGE-201-C2**. Finally, to reduce the risk that a TCR discovered in a targeted screen recognizes any problematic off-targets- **target interactions**, we re-screen the TCR using SafetyScan and our genome-wide library. When the TCR that recognizes **Target-MAGE-201-C2** was re-screened using our Oncology Target Discovery Library, which includes protein fragments spanning every normal protein encoded in the human genome, only one potential off-target **interaction** was observed. We subsequently identified several cell lines that naturally express the full-length protein from which the off-target antigen was derived and found that T cells engineered with the TCR do not recognize or kill these cells. Although the TCR recognizes target cells overexpressing protein fragments containing this off-target antigen, it does not recognize cells expressing the full-length protein at normal levels. This shows that our genome-wide screen detects potential off-targets with very high sensitivity, and that not all off-targets detected in this manner are problematic. In the event, however, that a TCR exhibits problematic off-target effects, we can use ReceptorScan to discover alternative TCRs that have similar anti-cancer effects but do not cross-react with proteins expressed at high levels on normal tissue or critical organs. To further expand the pool of addressable patients with our TSC-200 series of product candidates, we can also use ReceptorScan to identify TCRs recognizing antigens on the same target protein that are presented by different HLA alleles. Ultimately, we believe this strategy has the potential to enable multiplexed TCR-T therapy in which a patient is treated with more than one TCR for the same target protein, presented on two different HLA alleles. This approach could reduce the risk of resistance arising from loss, downregulation, or mutation of individual HLA genes.

TSC-200-20X Series Our six **clinical-stage** solid tumor TCR-T therapy candidates include a combination of known targets, such as HPV16 for TSC-200, **MAGE-A4 for TSC-202**, PRAME for TSC-203, and MAGE-A1 for TSC-204, as well as **a targets-target that are-is a novel antigens-antigen** for TCR-T therapy, such as **MAGE-C2** for TSC-201, **TSC-202**, and **TSC-205**. All of these targets are frequently expressed in the solid tumors of interest to us, including melanoma, head and neck cancer, NSCLC, and cervical cancer, **ovarian cancer, and anogenital cancer**. In **2022-2023**, it is estimated that in the U.S., approximately 100,000 patients **are were** diagnosed with melanoma, **66-67**, 000 with head and neck cancer, **185-200**, 000 with NSCLC, and **14**, 000 with cervical cancer, **20,000 with ovarian cancer, and 18,000 with anogenital cancer**. We **have plan to advance-advanced** a combination of known and novel targets into clinical development, which **will-is allow-allowing** us to use the product candidates targeting known antigens as backbones for our initial clinical trials evaluating multiplexed TCR-T therapy. For example, we plan to evaluate **TSC-200-203**, which targets **PRAME**, a well-known and clinically-validated **oncogenic-tumor-specific proteins-protein** derived from HPV16, in combination with TSC-201 and **targeting MAGE-C2**. **TSC-200 (HPV16) 202**, which **target antigens that have not yet been tested for TCR-T therapy**. In parallel with our TargetScan discovery efforts in head and neck cancer, we are using ReceptorScan to discover highly active TCRs that target antigens in human papilloma virus, or HPV, for our TSC-200 program. Over 25% of head and neck cancers are caused by HPV infection, including up to 70% of oropharyngeal cancers. HPV antigens are a particularly compelling set of targets **as due to the fact that** HPV proteins drive tumorigenesis in these cancers, which means that these proteins are (1) present in every tumor cell in an HPV-positive tumor and (2) essential to the survival of the tumor cell. In addition to head and neck cancers, HPV is found in more than 90% of cervical and **anal anogenital** cancers as well as over 60% of vaginal, vulval, and penile cancers. Recent Phase 1 clinical data from the National Cancer Institute showed tumor regression with objective clinical responses in 50% of patients with metastatic HPV-positive cancers who were treated with a TCR-T candidate targeting HPV16, which we believe provides clinical support for the inclusion of an HPV16-targeting TCR-T, **TSC-200-A0201**, in our multiplexed TCR-T **therapy-treatment** strategy. We have identified over a thousand TCRs that recognize HLA-A*02:01-specific antigens derived from HPV16, and **have we are currently identifying the most active TCR with a de-risked safety profile to advance-advanced TSC-200-A0201 (HPV16, HLA-A*02:01), into Phase 1 development**. We also intend to extend our discovery efforts to include additional HPV16-derived antigens presented on other HLA types as the program advances **-As detailed above, using such as TSC-200-C0702 (HPV16, HLA-C*07:02), currently in discovery. We are developing the TSC-201 series of candidates as TCR-Ts targeting melanoma-associated antigen C2, our-or TargetScan technology, we have-MAGE-C2. We initially identified MAGE-C2 what we refer to as Target-201, as one of three--the targets-target of from the T cells of from a melanoma patients-patient** responding to TIL therapy. **Target-MAGE-201-C2** is a CTA that is exclusively expressed in testis

and is not expressed in normal adult tissues. The testis is an immune-privileged tissue and, as a result, we believe that targeting Target-MAGE-201-C2 should not pose a significant safety concern. In addition, Target-MAGE-201-C2, which contributes to tumorigenesis by suppressing the cellular mechanisms responsible for controlling cell division, is selectively expressed across multiple different types of tumors, including approximately 50 % of melanomas, approximately 25 % of head and neck cancers, and approximately 50 % of non-small cell lung cancers. Tumors expressing Target-MAGE-201-C2 have been shown to be associated with metastasis and poor patient survival. We have identified two clinically active TCRs that recognize novel epitopes derived from Target-201 presented on two common HLA alleles, and we are currently evaluating which advancing three MAGE-C2 TCR-TCRs /Target; TSC-201 antigen pair to advance to IND-enabling studies B0702 (MAGE-C2, HLA-B * 07: 02), currently in Phase 1 development; TSC-201-A0201 (MAGE-C2, HLA-A * 02: 01), currently in discovery; and TSC-201-A2402 (MAGE-C2, HLA-A * 24: 02), currently in discovery. We are also using ReceptorScan to identify additional TCRs for Target-MAGE-201-C2 epitopes presented on other HLA alleles to further expand the ImmunoBank and increase the addressable patient population. TSC-202 (MAGE-A4) We have also identified and are developing the TSC-202 series of candidates as TCR-Ts targeting melanoma-associated antigen 4, or MAGE-A4. MAGE-A4 is a clinically established active TCRs targeting what we refer to as Target-202, which is a protein involved in cell invasion and migration that plays a role in the metastasis of tumors. Target-202 is a CTA that contributes to tumorigenesis by interfering with cell cycle arrest. MAGE-A4 is expressed only in 33 the placenta, with very low expression in testis and no expression in any other adult tissue. Increased expression of Target-202 is positively correlated with the degree of tumor invasion, lymph node metastasis, distant metastasis, and poor prognosis. Expression of Target-202 is especially high in HPV-positive tumors. Target-202 expression is repressed in normal tissue by the tumor suppressor protein p53. In HPV-driven carcinomas, however, the viral protein E6 causes degradation of p53, leading to increased expression of Target-202. As a result, high expression of Target-202 is observed in over 90% of cervical cancers enabling multiplexing with TSC-200, and approximately 75% MAGE-A4 is expressed in 50 % of non-small cell lung cancers, 40 % of head and neck cancers. Target-202 is also expressed in HPV-negative tumors, and 30 including approximately 40% of NSCLCs, over 95 % of melanomas; and up to 80 % of primary breast cancers. Using ReceptorScan, we have identified thousands of TCRs that recognize multiple HLA-A * 02: 01-specific epitopes derived from Target-MAGE-A4 and have advanced one MAGE-A4 TCR-T, TSC-202, and we are currently identifying the most active TCR to advance to IND-enabling studies A0201, into lead optimization. TSC-203 (PRAME) We are developing the TSC-203 series of candidates as a TCR-Ts therapy candidate targeting a known cancer antigen, Preferentially Expressed Antigen in Melanoma, or PRAME. Like MAGE Similar to Target-201-C2, PRAME contributes to tumorigenesis by suppressing cellular signals that control cell division, and higher expression levels of PRAME in tumors correlate with increased metastasis and poor patient outcomes. PRAME is a CTA that, like Target-MAGE-201-C2 and Target-MAGE-202-A4, is absent in adult tissues except in the ovaries and testis. Approximately 50 % of NSCLCs, approximately 25 % of cervical cancers, and approximately 90 % of both melanomas and head and neck cancers express PRAME. Moreover, PRAME expression is homogeneous within these tumors, which we believe make makes it an attractive target for multiplexed TCR-T therapy. Using ReceptorScan, we have identified thousands of TCRs across multiple PRAME-derived epitopes presented on HLA-A * 02: 01. We, and we are currently identifying advancing the three PRAME most active-TCR to advance to IND-enabling studies-Ts; TSC-203-A0201 (PRAME, HLA-A * 02: 01), currently in Phase 1 development; TSC-203-B0702 (PRAME, HLA-B * 07: 02), currently in lead optimization; and TSC-203-A2402 (PRAME, HLA-A * 24: 02) currently in discovery. In addition, we are using TargetScan on clinically active TCRs from patients with melanoma and head and neck cancer to identify novel PRAME epitopes presented on other HLA types. TSC-204 (MAGE-A1) We are developing the TSC-204 series of candidates as a TCR-Ts therapy candidate targeting a known cancer antigen, melanoma-associated antigen 1, or MAGE-A1, that will include multiple TCRs for different HLA-restricted epitopes on this target. Using our TargetScan platform we have identified MAGE-A1 as one of the targets of T cells from a head and neck cancer patient responding to checkpoint inhibitor therapy. From this patient, we discovered multiple different TCRs recognizing a novel HLA-C * 07: 02-restricted epitope of MAGE-A1 which is a cancer / testis gene frequently overexpressed in a wide variety of solid tumors, including approximately 45 % of head and neck cancers, 50 % of melanomas, 50 % of cervical cancers and 50 % of non-small cell lung cancers. In addition to Using our TargetScan platform, we initially identified MAGE-A1 as one of these-- the highly active targets of expanded T cells from a head and neck cancer patient responding to checkpoint inhibitor therapy. Multiple different TCRs from this patient recognize a novel HLA-C * 07: 02-restricted epitope of MAGE-A1, and one of these TCRs is the basis of TSC-204-C0702 (MAGE-A1, HLA-C * 07: 02), currently in phase 1 development. In addition to this TCR-T candidate, we are also further expanded the TSC-204 series by using ReceptorScan to identify additional clinical-TCRs for MAGE-A1 epitopes presented on multiple-several other common HLA alleles to further expand the addressable patient population. We are currently advancing five MAGE-A1 TScan believes that it is the only company with a disclosed TCR program in - Ts: TSC-204-A0201 (MAGE-A1 for, HLA-types other than A * 02: 01). The Company filed INDs for TSC-204-A0201 and TSC-204-C0702 in December 2022, currently and the FDA cleared these INDs in January 2023, allowing us to proceed with Phase 1 clinical development; enabling activities. We are developing TSC-204-205, a known cancer antigen, as a TCR-T therapy candidate. Expression of this antigen is distinct from our C0702 (MAGE-A1, HLA-C * 07: 02), current currently clinical targets, with especially prevalent expression in Phase 1 development; head and neck and non-small cell lung cancers. Using our ReceptorScan platform, we have generated candidate TCRs for two different epitopes derived from TSC-205-204-A0101 (MAGE-A1, HLA-A * 01: 01) currently in Phase 1 development; TSC-204-A0301 (MAGE-A1, HLA-A * 03: 01) currently in discovery; and TSC-204-B0702 (MAGE-A1, HLA-B * 07: 02) currently in discovery. In addition to our six lead solid tumor TCR-T therapy candidates, we have identified about 100 approximately 200 novel antigens as targets of tumor infiltrating T cells from patients who are responding to immunotherapy using TargetScan. Although target validation naturally

results in attrition, it is clear that tumor- resident T cells recognize many more shared antigens than have been reported to date. Many of the antigens we have identified are expressed across multiple solid tumor types and some have expression levels comparable or superior to targets currently in clinical development by others such as NY-ESO-1. We are currently in the process of validating several of these additional novel antigens and identifying potential TCR / target pairs using our platform technologies. We plan to continuously expand the ImmunoBank with TCRs for both known and novel targets as well as address different HLA types to enable customized multiplexed TCR- T therapy candidates while also addressing the potential issue of HLA loss leading to resistance for a wide range of solid tumor patients. Clinical Development Plan for Our Solid Tumor Program For the initial first- in- human studies for our TSC- 200-20X series of **TCR- T candidates, we are evaluating multiple TCRs in parallel to determine the safety and preliminary efficacy of multiplexed TCR- T therapy candidates, we plan to evaluate multiple TCRs in parallel to determine the safety and preliminary efficacy of multiplexed TCR- T therapy. The** In January 2023, the FDA **has** cleared our IND application for T- Plex, which **will serve serves** as the primary IND **application** for our solid tumor program, enabling customized **combinations simultaneous administration** of TCR- Ts to be administered to patients based on the targets and HLAs expressed in their tumors. Specific TCRs for each patient will be chosen from the ImmunoBank consisting of high affinity, naturally occurring TCRs that recognize a variety of prevalent cancer- specific targets and are associated with common HLA types. Each unique TCR- T will be filed as a secondary IND **application** and will reference the primary T- Plex IND **application**. In addition to the T- Plex IND **application**, the FDA **has** cleared secondary **INDs- IND applications** for **six two initial** TCR- T product candidates ;: TSC- 204-203 - A0201 and TSC- 204- C0702, targeting melanoma associated antigen 1- (**PRAME, MAGE- A1**) on HLA types - A * 02: 01 and); TSC- 200- A0201 (**HPV16, HLA- A * 02: 01**); TSC- 201- B0702 (**MAGE- C2, HLA- B * 07: 02**); TSC- 204- A0201 (**MAGE- A1, HLA- A * 02: 01**); TSC- 204- C0702 (**MAGE- A1, HLA- C * 07: 02 -**); and TSC- 204- A0101 (**MAGE- A1 is a cancer-associated antigen overexpressed in 45 % of head and neck cancers and 50 % of melanoma, cervical, and non-small cell lung cancers. We believe that TSC- 204- C0702 is the first clinical program in MAGE- A1 for an HLA - type other than A * 0201-01: 01**). We **have initiated** are now conducting activities to enable the initiation of a multicenter Phase 1 clinical trial to evaluate the safety, preliminary efficacy, and feasibility of repeat dosing of multiplexed TCR- T therapy. We plan to enroll patients with non- small cell lung cancer, melanoma, head and neck cancer, ovarian **cancer**, and cervical **cancer, and anogenital** cancer. We expect that many of the clinical trial sites enrolling patients in our hematologic malignancies program are planning to join our solid tumor Phase 1 study. We **are currently** plan to begin enrolling patients in the screening protocol of this study **by the middle of this year**, with patient dosing expected to commence in the **third first** quarter of 2023. We plan to share initial safety and biomarker data for the most advanced single- agent TCRs by the end of 2023, with initial multiplex therapy data for our first combination of TCRs under T- Plex expected in the first half of 2024. We plan to further populate the ImmunoBank with additional targets and HLA types, including cancer / testis antigens and TCRs targeted at epitopes of HPV. We envision these HPV- targeting TCRs will serve as a backbone therapy for patients with HPV- positive malignancies, including head and neck, cervical, and **anal anogenital** cancers. According to the Centers for Disease Control, the incidence of HPV- positive cancers in the U. S. is approximately 46, 000 cases per year, with five- year survival rates ranging from approximately 50 % to 70 %. The targets of TSC- 201, TSC- 202, TSC- 203, **and** TSC- 204, **and TSC- 205** are also frequently expressed in the solid tumors of interest to us, as shown below. Cancer Expression Levels for the Targets of our Lead Solid Tumor Programs After establishing single agent safety for each of our initial solid tumor TCR- T **therapy** candidates in a multi- arm Phase 1 clinical trial, we plan to test our **TSC- 200** series **200 of** TCR- Ts in combination with other TCRs in the ImmunoBank in patients who are positive for the respective targets of these therapies. We will also explore three- TCR **combinations simultaneous administrations** in patients who are positive for the three respective targets. Because the targets of TSC- 201, TSC- 202, TSC- 203, and TSC- 204 are also frequently expressed in melanoma and NSCLC, we will also explore various **combinations simultaneous administrations** of these TCR- T **therapy** candidates in patients with HPV- negative head and neck cancer, melanoma, and NSCLC. A summary of our planned Phase 1 clinical strategy is shown below. TSC- 200 Series Dose Escalation Scheme Provides Rapid Path to Testing and Expanding Multiplexed TCR- T in Phase 1 As we advance our solid tumor program, we anticipate submitting IND filings for additional TCRs throughout 2023. We expect to report initial safety data for the most advanced TCRs in this series by year end 2023, with multiplex therapy data anticipated in 2024. As we continue to discover and validate TCR / target pairs, we aim to continue to file additional **INDs- IND applications** and introduce those solid tumor TCR- T **therapy** candidates into this multi- arm basket- style Phase 1 clinical trial. We believe this trial will serve as the first step towards our long- term goal of **building and** expanding the ImmunoBank to provide customized multiplexed TCR- **Ts T therapy** for virtually any patient with a solid tumor malignancy . We plan to share initial data from the singleplex cohorts as well as initial multiplex data for our first **simultaneous administrations of TCRs under T- Plex in 2024, with long- term duration of response data for multiplexed therapy anticipated in 2025**. ImmunoBank – Flexible Content for Diverse Platforms Our current clinical development strategy is based on autologous T cell engineering, which is the basis for approved CAR- T products such as Kymriah and Yescarta. As the field of T cell engineering evolves, a wide variety of additional manufacturing platforms are being developed that may further improve TCR- T **cell** products. For example, companies such as Lyell Immunopharma, Inc. are developing methods to enhance autologous T cell engineering to provide improved duration of efficacy, while companies such as Allogene Therapeutics, Inc. are developing ways to engineer allogeneic T cells and companies such as **Sana Biotechnology Umoja Biopharma**, Inc. are developing ways to engineer T cells in vivo. All of these engineering platforms require validated “ content ” – TCRs that recognize tumor- specific antigens on cancer cells without recognizing problematic off- targets. As we advance the ImmunoBank of TCRs through clinical development, we intend to continue to build our own manufacturing platform, while simultaneously investigating novel T cell engineering platforms once they have established safety and efficacy. Ultimately, we aspire to build the largest collection of validated TCR “ content ” that can be used with a variety of T cell engineering platforms. Expansion Opportunities Beyond Oncology Our primary focus is on the development of T cell therapies to treat cancer.

However, T cells play a fundamental role in many other disease areas, such as infectious disease and autoimmune **disease disorders**. We believe that our TargetScan technology is well suited to discover novel antigens for the development of therapeutics, diagnostics, and vaccines in these other areas. We intend to build additional corporate value by opportunistically pursuing collaborations with strategic partners for applications of our platform technologies outside our core focus. Other Diseases TargetScan can also be used for novel target discovery in additional infectious **diseases** and autoimmune **diseases disorders**. For example, infections such as tuberculosis, influenza, and HIV have been shown to be T cell-mediated and are associated with high mortality rates. In addition, many autoimmune **diseases disorders** such as rheumatoid arthritis, psoriasis, and scleroderma are largely T cell-mediated, but with poorly defined instigating self-antigens. Our TargetScan technology, which provides an unbiased, genome-wide method to discover the natural targets of disease-relevant T cells, is well positioned to identify these self-antigens. We believe the discovery of these targets could enable the development of novel, more targeted therapeutic approaches to treat these diseases. License and Collaboration Agreements **Collaboration Agreement with Amgen On May 8, 2023, we entered into a Research Collaboration and License Agreement with Amgen Inc. (Amgen), or the Amgen Agreement, to identify antigens recognized by T cells in patients with Crohn's disease utilizing our proprietary target discovery platform, or TargetScan. Under the terms of the Amgen Agreement, Amgen will then evaluate a variety of modalities to create therapeutics based on targets discovered by TScan and will retain all global development and commercialization rights. Amgen made an upfront payment of \$ 30 million to us and we are eligible to earn success-based milestone payments of over \$ 500 million, based upon the achievement of certain development and commercial milestones, as well as tiered single-digit royalty payments on net sales of products developed from the collaboration, subject to reductions set forth in the Amgen Agreement.** Collaboration and License Agreement with Novartis On March 27, 2020, we entered into a Collaboration and License Agreement with Novartis Institutes for BioMedical Research, Inc. (Novartis) (such agreement, the Novartis Agreement). Pursuant to the Novartis Agreement, we have received an aggregate of \$ 20.0 million of cash representing the upfront payment and research funding ~~totalling~~ **totaling** \$ 10 million. We granted Novartis and its affiliates options to obtain exclusive, royalty-bearing, sublicensable, transferable, worldwide licenses to certain target antigens identified in performance of the Novartis Agreement and corresponding T cell receptors for such target antigens to make, have made, import, use, sell or offer for sale, including to develop, manufacture, commercialize, register, hold or keep, have used, export, transport, distribute, promote, market or have sold or otherwise dispose of such target antigens and corresponding T cell receptors. ~~Novartis can exercise each option by paying us \$ 10.0 million and can exercise up to three options (each target antigen for which Novartis exercises an option, an "Optioned Program").~~ In addition, we granted Novartis and its affiliates an option to obtain a non-exclusive, royalty-bearing, sublicensable, transferable, worldwide license under our intellectual property corresponding to products associated with such Optioned Program and improvements to our platform created in performance of activities under the Novartis Agreement, in each case, solely as necessary to exploit products associated with such Optioned Program. The ownership of inventions (and resulting patent rights) created in performance of the collaboration **was** will be determined by inventorship (i.e., inventions invented solely by us in performance of the collaboration and inventions invented solely by Novartis in performance of the collaboration will be owned by Novartis and inventions invented jointly by us and Novartis in performance of the collaboration will be jointly owned). We ~~retain~~ **retained** our rights to (i) our intellectual property, (ii) programs that are not selected by Novartis, and (iii) our platform improvements, which ~~will~~ **were** not be considered collaboration technology. **Our** Each party has the sole right (but not the obligation) in its sole discretion and cost, to prepare, file, prosecute and maintain all patents and patent applications that are owned solely by such party. For any collaboration **with** patents or patent applications owned by us, if we elect not to file a patent application or to cease the prosecution or maintenance of any of our collaboration patents or patent applications, we must notify Novartis **concluded** immediately of such decision, at which point Novartis will become permitted to file or continue prosecution or maintenance of such patent or patent application in our name. For joint collaboration patents and patent applications, Novartis has the first right (but not the obligation) to prepare, file, prosecute and maintain any joint collaboration patent or patent applications and / or optioned program patents or patent applications. For each Optioned Program, as between the parties Novartis is solely responsible for the clinical development of such Option Program. Novartis is required to pay us up to an aggregate of \$ 230.0 million upon achievement of certain clinical milestones and milestones for the first commercial sale in certain countries with respect to products directed to the corresponding target antigen for each Optioned Program. Novartis is also required to pay us up to an aggregate of \$ 260.0 million upon achievement of certain annual net sales milestones for products directed to the corresponding target antigen for each Optioned Program. In addition, for each Optioned Program, Novartis is required to pay us, on a product-by-product and country-by-country basis, tiered royalties in the low-single-digit to mid-single-digit percentage on Novartis', its affiliates' and sublicensees' net sales of certain products directed to target antigens for each Optioned Program and a percentage in the mid-single-digits to low-teens on Novartis' net sales of products directed to such antigens and containing a T cell receptor we identified to Novartis in our performance of the Novartis Agreement, subject to certain customary reductions. Royalties will be payable on a product-by-product and country-by-country basis during the period of time commencing on the first commercial sale of an applicable product in a country and ending upon the later of: (a) 10 years from the date of first commercial sale of such product in such country; (b) expiration of the last-to-expire valid claim of patents licensed by us to Novartis under the Novartis Agreement covering the manufacture, use or sale of such product in such country; or (c) the expiration of any regulatory or marketing exclusivity in such country with respect to such product (the "Royalty Term"). Novartis may terminate the Novartis Agreement entirely or on a program-by-program basis at any time for convenience upon 90 days' notice; provided, however, that Novartis will be required to fulfill any payment obligations that accrued prior to termination. For a period of up to 180 days after the end of the collaboration period (which collaboration period is anticipated to end in March 2023), we agree to notify Novartis if we intend to seek a third party partner to exclusively license or similarly grant rights to patents or know-how developed by us under the collaboration to allow for the development or commercialization

of products directed to any programs that Novartis has not exercised an option to prior to the expiration of such option (a ROFN Notice). Upon receiving such notice, Novartis will have 90 days to provide us with a term sheet to exclusively license such collaboration technology to develop or commercialize products directed to such previously declined program, which will trigger Novartis' s right of first negotiation. If Novartis delivers such term sheet, then Novartis will have 270 days following the ROFN Notice to negotiate a license for such collaboration technology. The Novartis Agreement will remain in effect until (i) all options expire unexercised or (ii) if any options are exercised, on a product-by-product and country-by-country basis for each Optioned Program, upon the expiration of the Royalty Term for all products associated with such Optioned Program in such country. Either party may terminate the Novartis Agreement upon an uncured material breach of the agreement or insolvency of the other party. We may terminate the Novartis Agreement immediately upon written notice to Novartis if Novartis challenges the validity, enforceability or scope of any of the patents we license to Novartis under the agreement. Novartis may terminate the agreement, either in its entirety or on a program-by-program basis, for convenience at any time with 90 days' prior written notice. Exclusive Patent License Agreement with BWH On December 5, 2018, we entered into an Exclusive Patent License Agreement with The Brigham and Women' s Hospital, Inc., or BWH, as amended on July 26, 2019 and further amended and restated on April 20, 2021, or, collectively, the BWH Agreement, pursuant to which we obtained an exclusive, sublicensable, worldwide license to practice under certain of BWH' s patent rights for identifying T Cell-cell epitopes, which are relevant to our TargetScan technology for identifying potential therapeutic products. The original 2018 BWH Agreement granted us the right to practice BWH' s patent rights in a certain field of use, MHC Class I License Field. In connection with the amended and restatement of the BWH Agreement in 2021, we expanded the field of use in which we are authorized to practice BWH' s patent rights to include MHC Class II uses and applications in exchange for certain additional payments to BWH. We are obligated to use commercially reasonable efforts to develop and commercialize at least one product or process that practices the licensed patent rights and at least one therapeutic or diagnostic product or process directed to an epitope identified through practicing the licensed patent rights. Upon execution of the amendment of the BWH Agreement dated April 20, 2021, we paid an additional one-time fee of \$ 466, 500. We are required to pay BWH up to an aggregate of \$ 12. 72 million upon the achievement of certain clinical, regulatory and sales milestones for therapeutic products and processes. We are obligated to pay a low double-digit percentage of all non-royalty income we receive under sublicenses of BWH' s patent rights. We are also obligated to pay a low single-digit percentage of all non-royalty income we receive under agreements with third parties, or Collaborators, where we practice under BWH' s patent rights in connection with the research or development of one or more therapeutic products or processes with or for such third party, or Collaboration Agreements. We are also obligated to pay tiered royalties in the high single-digit percentage range on annual net sales of products and processes that practice the licensed patent rights and in the low single-digit percentage range on annual net sales of therapeutic and diagnostic products and processes directed to an epitope identified through practicing the licensed patent rights (other than those sold by Collaborators), with the royalty percentage for such products and processes decreasing to lower than one-percent royalties if directed to epitopes identified through practicing the licensed patent rights after December 31, 2019. For therapeutic and diagnostic products and processes directed to an epitope identified through practicing the licensed patent rights and sold by a Collaborator, we are obligated to pay lower than one-percent royalties of the Collaborator' s annual net sales of such products and processes. For products and processes sold by us, our affiliates or sublicensees, such royalties only apply to products and processes directed to epitopes in a defined field of use MHC Class I field identified prior to December 31, 2022, and products and processes based on epitopes in the MHC Class II field identified prior to September 30, 2023. For products or processes directed to epitopes identified under a Collaboration Agreement, such royalties apply regardless of when the epitopes were identified. For each applicable product or process, the royalty term continues until the tenth (10th) anniversary of the first commercial sale of such product or process. The royalty rates are also subject to reduction upon certain other events. Within sixty (60) days of each anniversary of December 5th, we are obligated to pay BWH a non-refundable, mid-five-figure minimum annual royalty, which amount is creditable against royalties subsequently due on net sales of products and processes in such calendar year. The BWH Agreement will terminate upon the later of (a) the last to expire or abandoned valid claim within the licensed patents, and (b) one year after the last sale for which a royalty is due. The current expected expiration date for the last-to-expire licensed patent right is June 8, 2038 (absent any adjustments or extensions of term). We also have the right to terminate the BWH Agreement in its entirety or on a country-by-country basis, for any reason upon 90 days' prior written notice to BWH. BWH may terminate the BWH Agreement: (1-i) without notice if we fail to maintain insurance required by the BWH Agreement; (2-ii) upon notice within 60 days of our bankruptcy; (3-iii) upon notice within 60 days after notice by BWH of our default in the performance of any obligation under the BWH Agreement that is not cured within such 60-day period; (4-iv) if we fail to make any payments due under the BWH Agreement and do not cure such failure within 10 days after receiving BWH notice thereof; or (5-v) if we or any of our affiliates challenge the validity, enforceability or scope of any of the patent rights licensed to us under the BWH Agreement. Non- Exclusive License Agreement with Provincial Health Services Authority On October 15, 2020, we entered into a Non- Exclusive License Agreement with the Provincial Health Services Authority of British Columbia, or PHSA, and such agreement, the PHSA Agreement. Pursuant to the PHSA Agreement, we obtained a non-exclusive, perpetual, non-transferable, sublicensable, worldwide license to practice certain of PHSA' s patent rights for identifying T Cell-cell epitopes, which epitopes are relevant to our platform for identifying potential TCR- T therapies. Any sublicenses we grant to PHSA' s patent rights must also include a license of our own IP-intellectual property; we are not permitted to sublicense PHSA' s rights on a standalone basis. Pursuant to the PHSA Agreement, we paid PHSA a one-time, non-refundable upfront fee of \$ 500, 000 as well as a reimbursement for previously incurred patent prosecution costs of approximately \$ 50, 000. Starting on the first anniversary of the effective date of the PHSA Agreement and continuing for five years thereafter, we are required to pay PHSA a mid-five-figure annual license fee, of which the first installment has been paid. In addition, we are obligated to pay a mid-six-figure fee for each sublicense and each further sublicense granted by one of our sublicensees or a sublicensee of our

sublicensee (through multiple tiers) of the rights granted to us under the PHSA Agreement. The PHSA Agreement will terminate upon the last to expire patent licensed under the PHSA Agreement. We also have the right to terminate the PHSA Agreement at any time, but such termination will not be effective until the later of (a) October 16, 2023, and (b) the date we have paid PHSA total aggregate fees equal to the upfront fee plus five years of annual license fees totaling \$ 750, 000. PHSA may terminate the PHSA Agreement upon giving us two separate written notices at least 30 days apart if: (i) we or any of our affiliates challenge the validity, enforceability or scope of any of the patents licensed to us under the PHSA Agreement; (ii) we owe unpaid fees due under the PHSA Agreement in excess of \$ 100, 000; or (iii) we breach material terms of the PHSA Agreement regarding sublicense restrictions (such as failing to pay the sublicense fee or sublicensing PHSA technology on a standalone basis) or our obligation to indemnify PHSA for damages resulting from our research or commercialization of PHSA's patent rights and, in each case described above, such termination will be effective only if we fail to cure such breach after receiving PHSA's two separate notices. Royalty Agreement In connection with our incorporation in April 2018, we entered into a royalty agreement with one of our founders. We amended and restated this royalty agreement in June 2018 and our founder assigned his rights and obligations under the royalty agreement to one of his affiliated entities in January 2021. Pursuant to the royalty agreement, we are required to pay him a royalty of 1 % of net sales (as defined in the royalty agreement) of any product sold by us or by any of our direct or indirect licensees for use in the treatment of any disease or disorder covered by a pending patent application or issued patent held or controlled by us as of the last date that the founder was providing services to us as a director or consultant under a written agreement. Royalties are payable with respect to each applicable product on a country- by- country and product- by- product basis, beginning on the first commercial sale of the first royalty- bearing product and ending on the later of (i) the date on which the exploitation of such royalty- bearing product is no longer covered by such patent in such country or (ii) the 15th anniversary of the first commercial sale of the first royalty- bearing product in such country. We may not assign our rights and obligations under the royalty agreement except in the event of a change in control relating to our company. The term of the royalty agreement continues until expiration of the last applicable royalty term. We have built in- house cell therapy manufacturing capabilities as one of the key components of our platform. The manufacturing of cell therapies requires the integration of several distinct components. Primary human blood cells are the source of T cells, along with a vector that delivers the desired genetic elements into these T cells. As a more operationally flexible and cost- efficient alternative to lentivirus, we have developed a manufacturing platform to genetically engineer T cells using a transposon / transposase system, which we refer to as T- Integrate. We are designing our programs to use a transposon vector and corresponding transposase enzyme, which is derived from *SfR fall armyworm*, to deliver our TCRs into the genome of T cells. Our transposon / transposase system effectively inserts our TCRs and other exogenous genes, such as CD8, at random locations in the genome. The transposon will be delivered as a Nanoplasmid TM, which was developed by Nature Technology, an Aldevron Company, and has no antibiotic selection element, reducing the risk of inadvertent transmission of antibiotic resistance into T cells. The transposase will be delivered as mRNA. mRNA is transiently expressed in the cell, reducing exposure of cells to prolonged transposase activity, which could result in multiple transposition events where the transposon would be moved around the genome. Aldevron has a license from Nature Technology to manufacture research- grade and GMP- grade transposon and transposase. We are developing our ~~have developed a~~ manufacturing process ~~currently producing product for clinical studies,~~ using industry standard ~~equipment and instrumentation.~~ ~~The equipment and instrumentation used in our~~ ~~to enable direct transfer of methods from process development to manufacturing facility.~~ ~~These devices also allow~~ ~~allows~~ for functionally closed processes in a small footprint. For ~~clinical~~ product manufacturing, we use single- use bag and tubing kits, supplies, and process reagents that are available from well- established vendors who specialize in supplying clinical grade reagents for the cell and gene therapy industry. Our TCR- T ~~therapies will be candidates are released and characterized and released~~ using well- developed ~~analytic-analytical~~ methods. The final product will be ~~used in clinical studies is~~ cryopreserved, simplifying logistics and reducing risk of delivery failures ~~to support patient dosing.~~ We ~~plan to~~ have controls and safeguards throughout the entire process to ensure product identity, integrity, ~~sterility,~~ and chain of custody. A clearly defined and documented manufacturing process, performed by trained operators using specialized instrumentation in an appropriately designed, commissioned, and operated manufacturing facility ~~is~~ ~~are all~~ critical for the manufacturing of safe, effective, and well- characterized cell therapies. Our cell product manufacturing facility in Waltham, MA ~~was has been~~ designed and built to support multiple programs through Phase 1 and Phase 2 clinical development, with a projected capacity to support ~~treating over 300 patients~~ ~~up to 250 TCR- T components~~ per year. We believe internalizing our manufacturing process ~~and product testing~~ enables us to better control this key aspect of clinical development and reduces the risk of program delay due to third- party reliance. We expect to revisit our manufacturing process prior to commencing registrational trials and may use third- party ~~contract manufacturing organizations (CMOs-- CMO)~~ ~~to increase our capacity in support of manufacture-manufacturing~~ product candidates for our registrational trials. Competition We believe our novel and proprietary platform technologies, TargetScan, SafetyScan, and ReceptorScan, and our in- house cell therapy expertise constitute a meaningful competitive advantage in successfully developing novel and highly ~~safe and~~ effective treatments for cancer. However, the biopharmaceutical industry in general, and the cell therapy field in particular, is characterized by rapidly advancing and changing technologies, intense competition, and a strong emphasis on intellectual property. We face substantial and increasing competition from many different sources, including large and specialty biopharmaceutical companies, academic research institutions, governmental agencies, and public and private research institutions. Competitors may compete with us in hiring scientific and management personnel, establishing clinical study sites, recruiting patients to participate in clinical trials, and acquiring technologies complementary to, or necessary for, our programs. We face competition from segments of the pharmaceutical, biotechnology and other related markets that pursue the development of TCR- ~~T-based~~ ~~or other-cell - based~~ therapies for the treatment of cancer. We expect to compete with a number of other ~~T- TCR- based companies, utilizing both~~ cell therapy ~~and other therapeutic modalities~~ companies, including those with target discovery platforms, such as Adaptive Therapeutics, Inc., Immatics N. V., ~~Adaptimmune Therapeutics, Plc.,~~

Affini- T Therapeutics, Inc., Medigene AG, T- Knife GmbH, Enara Bio Ltd., Repertoire Immune **Immunocore** Medicines **Holdings, Inc Plc**, and 3T Biosciences Inc. In addition, we may face competition from other TCR companies such as **Adaptimmune Therapeutics, Plc., Medigene AG, Affini- T Therapeutics, Inc., T- Knife GmbH, and Alamos Therapeutics, Inc.** We may also face competition from companies focused on **CAR- T, TIL, gammadelta T cell, and other T cell therapies (e. g., TIL, CAR- T, gammadelta T cells)** such as **Iovance Biotherapeutics, Inc., Instil Bio, Inc., Achilles Therapeutics plc**, Kite Pharma, Inc., a subsidiary of Gilead, Inc. (including Yescarta, which is approved for the treatment for large B cell lymphoma or follicular lymphoma, two types of non- Hodgkin lymphoma), Juno Therapeutics, Inc., a subsidiary of Bristol- Myers Squibb, Inc., **Iovance Biotherapeutics Regeneron Pharmaceuticals, Inc., Instil through their acquisition of 2seventy Bio, Inc.' s research pipeline**, **Achilles AstraZeneca plc, through their acquisition of Gracell Biotechnologies, Inc., Legend Biotech Corporation, Autolus** Therapeutics plc, Sana Biotechnology, Inc., **2seventy Bio, Inc., Atara Biotherapeutics, Inc., Lyell Immunopharma, Inc., Allogene Therapeutics, Inc., Gadeta B. V., and Adicet Bio, Inc.** There are also companies utilizing other cell- based approaches that may be competitive to our product candidates. For example, companies such as Takeda Pharmaceutical Company, Ltd., **Sanofi S. A., through their acquisition of Kiadis Pharma N. V.,** Celyad, S. A., ImmunityBio, Inc., Celularity, Inc., Fate Therapeutics, Inc., and Nkarta, Inc. are developing therapies that target and / or engineer natural killer, or NK, cells. In addition, for our lead programs, TSC- 100 and TSC- 101, we may face competition from BlueSphere Bio, **NexImmune, Inc., VOR Biopharma, Inc., IN8bio**, Inc., and Marker Therapeutics, Inc., who are also developing cell therapies in the post- HCT setting. The named companies are not fully inclusive of all possible competitive threats. **Immunocore's KIMMTRAK is the first TCR- based therapeutic to receive FDA approval, potentially establishing a regulatory pathway, pricing benchmark, and commercial uptake pattern for TCR- based therapeutics.** However, KIMMTRAK is a bispecific antibody indicated for use in a rare patient population with unresectable or metastatic uveal melanoma, which is not directly competitive to TSean and may have different market access and commercial uptake dynamics. **Immunocore's other programs using TCR- mimetic bispecifics in other indications such as cutaneous melanoma may be a more direct competitor to TSean's products.** Furthermore, we also face competition more broadly across the oncology market for cost- effective and reimbursable cancer treatments. The most common methods of treating patients with cancer are surgery, radiation, and drug therapy, including chemotherapy, hormone therapy, biologic therapy, such as monoclonal and bispecific antibodies, immunotherapy, cell- based therapy, and targeted therapy, or a combination of any such treatments. There are a variety of available drug therapies marketed for cancer. In many cases, these drugs are administered in combination to enhance efficacy. While our TCR- T therapy candidates, if any are approved, may compete with these existing drugs and other therapies, to the extent they are ultimately used in combination with or as an adjunct to these therapies, our TCR- **Ts T therapies** may not be competitive with them. Some of these drugs are branded and subject to patent protection, and others are available on a generic basis. As a result, obtaining market acceptance of, and gaining a significant share of the market for, and commanding a certain price for any of our TCR- **Ts T therapies** that we successfully introduce to the market may pose challenges. In addition, many companies are developing new oncology therapeutics, and we cannot predict what the standard of care will be as our product candidates progress through clinical development. We could see a reduction or elimination in our commercial opportunity if our competitors develop and commercialize drugs that are safer, more effective, have fewer or less severe side effects, are more convenient to administer, are less expensive, are more accessible, or receive a more favorable label than our TCR- T therapy candidates. Our competitors also may obtain FDA or other regulatory approval for their drugs more rapidly than we may obtain approval for ours, which could result in our competitors establishing a strong market position before we are able to enter the market. The key competitive factors affecting the success of all of our TCR- **therapy** candidates, if approved, are likely to be their efficacy, safety, convenience, **accessibility**, price, and the availability of reimbursement from government and other third- party payors. Our success depends in part on our ability to obtain, maintain and protect our proprietary technology and intellectual property and proprietary rights and to operate our business without infringing, misappropriating and otherwise violating the intellectual property and proprietary rights of third parties. We rely on a combination of patent applications, trademarks, trade secrets, and other intellectual property rights and measures to protect the intellectual property rights that we consider important to our business. We also rely on know- how and continuing technological innovation to develop and maintain our competitive position. We also seek to protect our proprietary rights by entering into confidentiality agreements and proprietary information agreements with suppliers, employees, consultants and others who may have access to our proprietary information. The steps we have taken to protect our trade secrets, trademarks, patent applications and other intellectual property and proprietary rights may not be adequate, and third parties could infringe, misappropriate or misuse our intellectual property. If this were to occur, it could harm our reputation and adversely affect our business, competitive position, financial condition or results of operations. As of the date hereof, our patent portfolio includes a patent family exclusively licensed from BWH, including a **granted U. S. patent, a** pending U. S. non- provisional patent application, and multiple **pending- foreign granted patents and** non- provisional patent applications, relating to methods and compositions for identifying target antigens specific to T cells. In addition, we have filed applications in multiple patent families including multiple pending U. S. provisional patent applications, **multiple granted foreign patents,** and more than **ten- 70** pending international and foreign patent applications. The claims of these patent applications are directed toward various aspects of our therapy candidates and research programs, including compositions of matter directed to SARS- CoV- 2 immunodominant antigens, anti- SARS- CoV- 2 TCRs, anti- SARS- CoV- 2 vaccines, anti- HA- 1 TCRs (including the TSC- 100 TCR- **therapy** candidate), anti- HA- 2 TCRs (including the TSC- 101 TCR- **therapy** candidate), anti- HPV TCRs (including the TSC- 200 TCR- **T therapy candidate**), **anti- MAGE- C2 TCRs (including the TSC- 201 TCR- T** candidate), anti- PRAME TCRs (including the TSC- 203 TCR- **T therapy** candidate), and anti- MAGE- A1 TCRs (including the TSC- 204 TCR- **T therapy** candidate), as well as platform technologies including a phospholipid scrambling reporter- based T cell antigen screening platform and certain screening methods thereof, and a TCR multiplexing platform and certain therapeutic methods thereof. These patent applications, if issued, are expected to expire on

various dates from 2038 through 2043-2044, in each case without taking into account any possible patent term adjustments or extensions and assuming that appropriate maintenance and governmental fees are paid. Hematologic Malignancies Program Product Patent Families We have filed multiple pending patent applications covering aspects of our hematologic malignancies programs including claims to the composition- of- matter of TSC- 100, TSC- 101, and other anti- HA- 1 and anti- HA- 2 TCRs and related T cell therapies. The pending international Patent Cooperation Treaty (PCT) application applications will begin began to enter the national and regional phases by in May 2023. The pending international Patent Cooperation Treaty (PCT), Australian, Argentine, and Taiwanese patent applications claim the benefit of priority from earlier- filed U. S. priority provisional patent applications filed in 2020 and 2021. We expect the issued Australian patent patents and any additional patents within this family, if issued, to expire no earlier than 2041 (without taking into account any possible patent term adjustments or extensions and assuming that appropriate maintenance and governmental fees are paid). Solid Tumor Program Product Patent Families We have filed multiple pending U. S. provisional and PCT international patent applications covering aspects of our solid tumor programs including claims to the composition- of- matter of anti- HPV, anti- MAGE- C2, anti- PRAME, anti- MAGE- A1 TCRs, and related T cell therapies. The pending patent applications will begin began to enter the national and regional phases by in October 2023. We expect any patents within this family, if issued, to expire no earlier than 2042 (without taking into account any possible patent term adjustments or extensions and assuming that appropriate maintenance and governmental fees are paid). Infectious Disease Product Patent Families We have filed multiple pending patent applications covering aspects of our infectious disease programs including claims to the composition- of- matter of SARS- CoV- 2 immunodominant antigens, anti- SARS- CoV- 2 TCRs, and the composition- of- matter of certain SARS- CoV- 2 vaccines. These pending international PCT, U. S., Australian, Canadian, European, Japanese, Argentine, Bangladeshi, Democratic Republic of the Congo, Pakistani, and Taiwanese patent applications claim the benefit of priority from earlier- filed U. S. priority provisional patent applications filed in 2020. We expect the issued Australian patent, the Democratic Republic of the Congo patent, and any additional patents within this family, if issued, to expire no earlier than 2041 (without taking into account any possible patent term adjustments or extensions and assuming that appropriate maintenance and governmental fees are paid). Certain of these pending patent applications are jointly owned by us and AHS Hospital Corporation, or AHS. AHS has exclusively licensed their interest in such patent applications to us. Platform Technology We own a pending PCT patent application with claims that cover aspects of our reporter- based T cell antigen screening platform. We expect any claims within this family, if issued, to expire no earlier than 2041 (without taking into account any possible patent term adjustments or extensions and assuming that appropriate maintenance and governmental fees are paid). We also own a family of pending provisional patent applications with claims that cover multiplexed TCR compositions and certain therapeutic methods thereof. We expect any claims within this family, if issued, to expire no earlier than 2043 (without taking into account any possible patent term adjustments or extensions and assuming that appropriate maintenance and governmental fees are paid). Our pending patent applications may not result in issued patents and we can give no assurance that any patents that might issue in the future will protect our products or provide us with any competitive advantage. Moreover, U. S. provisional patent applications are not eligible to become issued patents until, among other things, we file a non- provisional patent application within 12 months of filing of one or more of our related provisional patent applications. With regard to such U. S. provisional patent applications, if we do not timely file any non- provisional patent applications, we may lose our priority date with respect to our provisional patent applications and any patent protection on the inventions disclosed in our provisional patent applications. While we generally intend to timely file non- provisional patent applications relating to our provisional patent applications, we cannot predict whether any such patent applications will result in the issuance of patents that provide us with any competitive advantage. For more information regarding the risks related to our intellectual property, please see “ Risk Factors — Risks Related to Our Intellectual Property ”. Third- Party Intellectual Property Rights For certain aspects of our business, we rely on certain technology and intellectual property rights that we in- license from third parties. We have an exclusive patent license from The Brigham and Women’s Hospital, Inc. (BWH) to a patent family directed to aspects of a granzyme B (GzB)- based antigen screening technology platform, as well as compositions- of- matter and certain screening methods thereof (consisting of one granted U. S. patent, one pending U. S. patent application, a granted patent in each of Australia and Japan, and six foreign patent applications pending in Australia, Canada, China, Europe, Hong Kong, and Japan). Any patents issuing from the U. S. and foreign patent applications are expected to expire no earlier than 2038 (without taking into account any possible patent term adjustments or extensions and assuming that appropriate maintenance and governmental fees are paid). We also have a non- exclusive, perpetual, non- transferable patent license from the Provincial Health Services Authority of British Columbia (PHSA) to a patent family directed to granzyme- based antigen screening methods consisting of an issued U. S. patent that is expected to expire on August 4, 2035 (assuming that appropriate maintenance and governmental fees are paid), a pending U. S. patent application, and issued Canadian patent that is expected to expire March 25, 2035 (assuming that appropriate maintenance and governmental fees are paid). We do not have any additional material licenses to any technology or intellectual property rights. As of the date hereof, we own or have rights to U. S. and foreign trademark registrations and applications that cover certain aspects of our business. FDA Regulation and Marketing Approval In the U. S., the FDA regulates drugs under the Federal Food, Drug and Cosmetic Act, or FDCA, and biologics under the Public Health Service Act, the regulations promulgated under both laws and other federal, state, and local statutes and regulations. Failure to comply with the applicable U. S. regulatory requirements at any time during the product development process, approval process or after approval may subject an applicant to administrative or judicial sanctions and non- approval of product candidates. These sanctions could include, among other things, the imposition by the FDA of a clinical hold on trials, the FDA’s refusal to approve pending applications or related supplements, withdrawal of an approval, untitled or warning letters, product recalls, product seizures, total or partial suspension of production or distribution, injunctions, fines, restitution, disgorgement, civil penalties, or criminal prosecution. Such actions by government agencies could also require us to expend a large amount of resources to respond to the actions. Any

agency or judicial enforcement action could have a material adverse effect on us. The FDA and comparable regulatory agencies in state and local jurisdictions and in foreign countries impose substantial requirements upon the clinical development, approval, manufacture, distribution and marketing of pharmaceutical products. These agencies and other federal, state and local entities regulate research and development activities and the testing, manufacture, quality control, safety, effectiveness, labeling, packaging, storage, distribution, record keeping, approval, post- approval monitoring, advertising, promotion, sampling and import and export of our products. ~~Our Rocket's~~ drugs must be approved by the FDA as biologics through the BLA approval process applicable to gene therapy product candidates, before they may be legally marketed in the U. S. Within the FDA, the FDA's Center for Biologics Evaluation and Research, or CBER, regulates gene therapy products and has published guidance documents with respect to the development ~~of~~ these types of products. The FDA also has published guidance documents related to, among other things, gene therapy products in general, their preclinical assessment, observing subjects involved in gene therapy studies for delayed adverse events, potency testing, and chemistry, manufacturing and control information in gene therapy INDs. The process required by the FDA before a biologic may be marketed in the ~~United States~~ **U. S.** generally involves the following: • completion of non- clinical laboratory tests, animal studies and formulation studies conducted according to Good Laboratory Practice, or GLP, or other applicable regulations; • submission of an IND **application**, which allows clinical trials to begin unless ~~the~~ FDA objects within 30 days; • performance of adequate and well- controlled human clinical trials to establish the safety and efficacy of the proposed drug or biologic for its intended use or uses conducted in accordance with FDA regulations and Good Clinical Practices, or GCP, which are international ethical and scientific quality standards meant to ensure that the rights, safety and well- being of trial participants are protected, and that the integrity of the data is maintained; • preparation and submission to the FDA of a BLA; • submission of a user fee for FDA review of the BLA; • review of the product by an FDA advisory committee, where appropriate or if applicable; • satisfactory completion of pre- approval inspection of manufacturing facilities and clinical trial sites at which the product, or components thereof, are produced to assess compliance with current Good Manufacturing Practice, or cGMP, requirements, and if applicable, the FDA's current Good Tissue Practice, or cGTP, requirements, and of selected clinical trial sites to assess compliance with GCP requirements; and • FDA approval of a BLA which must occur before a biologic can be marketed or sold. Preclinical Studies Preclinical studies include laboratory evaluation of the purity and stability of the manufactured drug substance or active pharmaceutical ingredient and the formulated drug or drug product, as well as in vitro and animal studies to assess the safety and activity of the drug for initial testing in humans and to establish a rationale for therapeutic use. The conduct of preclinical studies is subject to federal regulations and requirements, including GLP regulations. The results of the preclinical tests, together with manufacturing information, analytical data, any available clinical data or literature and plans for clinical studies, among other things, are submitted to the FDA as part of an IND **application**. Companies usually must complete some long- term preclinical testing, such as animal tests of reproductive adverse events and carcinogenicity and must also develop additional information about the chemistry and physical characteristics of the drug and finalize a process for manufacturing the drug in commercial quantities in accordance with, or cGMP, requirements. The manufacturing process must be capable of consistently producing quality batches of the drug candidate and, among other things, the manufacturer must develop methods for testing the identity, strength, quality, and purity of the final drug product. Additionally, appropriate packaging must be selected and tested, and stability studies must be conducted to demonstrate that the drug candidate does not undergo unacceptable deterioration over its shelf life. IND **Application** and Clinical Trials Clinical trials involve the administration of the investigational product to human subjects under the supervision of qualified investigators in accordance with GCP requirements. Clinical trials are conducted under written study protocols detailing, among other things, the objectives of the study, the parameters to be used in monitoring safety and the effectiveness criteria to be evaluated. Prior to commencing the first clinical trial, an initial IND **application**, which contains the results of preclinical testing along with other information, such as information about product chemistry, manufacturing and controls and a proposed protocol, must be submitted to the FDA. The IND **application** automatically becomes effective 30 days after receipt by the FDA unless the FDA, within the 30- day time period, raises concerns or questions about the drug product or the conduct of the clinical trial and imposes a clinical hold. A clinical hold may also be imposed at any time while the IND **application** is in effect. In such a case, the IND ~~- application~~ sponsor must resolve any outstanding concerns with the FDA before the clinical trial may begin or re- commence. Accordingly, submission of an IND **application** may or may not result in the FDA allowing clinical trials to commence or continue. In addition to the submission of an IND **application** to the FDA before initiation of a clinical trial in the ~~United States~~ **U. S.**, certain human clinical trials involving recombinant or synthetic nucleic acid molecules are subject to oversight of institutional biosafety committees, or ~~IBC-IBCs's~~, as set forth in the National Institutes for Health, or NIH, Guidelines for Research Involving Recombinant or Synthetic Nucleic Acid Molecules, or NIH Guidelines. Under the NIH Guidelines, recombinant and synthetic nucleic acids are defined as: (i) molecules that are constructed by joining nucleic acid molecules and that can replicate in a living cell (i. e., recombinant nucleic acids); (ii) nucleic acid molecules that are chemically or by other means synthesized or amplified, including those that are chemically or otherwise modified but can base pair with naturally occurring nucleic acid molecules (i. e., synthetic nucleic acids); or (iii) molecules that result from the replication of those described in (i) or (ii). Specifically, under the NIH Guidelines, supervision of human gene transfer trials includes evaluation and assessment by an IBC, a local institutional committee that reviews and oversees research utilizing recombinant or synthetic nucleic acid molecules at that institution. The IBC assesses the safety of the research and identifies any potential risk to public health or the environment, and such review may result in some delay before initiation of a clinical trial. While the NIH Guidelines are not mandatory unless the research in question is being conducted at or sponsored by institutions receiving NIH funding of recombinant or synthetic nucleic acid molecule research, many companies and other institutions not otherwise subject to the NIH Guidelines voluntarily follow them. A sponsor who wishes to conduct a clinical trial outside the U. S. may, but need not, obtain FDA authorization to conduct the clinical trial under an IND **application**. If a foreign clinical trial is not conducted under an IND **application**, the sponsor may submit data from the clinical trial to the FDA

in support of a BLA or IND **application** so long as the clinical trial is conducted in compliance with GCP, and the FDA is able to validate the data from the study through an onsite inspection if the agency deems it necessary. A separate submission to the existing IND **application** must be made for each successive clinical trial to be conducted during product development. Further, an independent Institutional Review Board, or IRB, for each site at which the clinical trial will be conducted must review and approve the clinical trial before it commences at that site. Informed written consent must also be obtained from each trial subject. Regulatory authorities, including the FDA, or IRB, or the sponsor, may suspend or terminate a clinical trial at any time on various grounds, including a finding that the participants are being exposed to an unacceptable health risk or that the clinical trial is not being conducted in accordance with FDA requirements. Additionally, some clinical trials are overseen by an independent group of qualified experts organized by the clinical trial sponsor, known as a data safety monitoring board or committee. This group provides authorization as to whether or not a trial may move forward at designated check points based on access to certain data from the trial and may recommend halting the clinical trial if it determines that there is an unacceptable safety risk for subjects or other grounds, such as no demonstration of efficacy. Human clinical trials for BLA approval typically involve a three- phase process, although some phases may overlap or be combined. Phase 1, the initial clinical evaluations, consists of administering the drug and testing for safety and tolerated dosages and in some indications such as rare disease, as preliminary evidence of efficacy in humans. Phase 2 involves a study to evaluate the effectiveness of the drug for a particular indication and to determine optimal dosage and dose interval and to identify possible adverse side effects and risks in a larger patient group. When a product is found safe, and initial efficacy is established in Phase 2, it is then evaluated in Phase 3 clinical trials. Phase 3 trials consist of expanded multi- location testing for efficacy and safety to evaluate the overall benefit- to- risk index of the investigational drug in relationship to the disease treated. The results of preclinical and human clinical testing are submitted to the FDA in the form of a BLA for approval to commence commercial sales. All clinical trials must be conducted in accordance with FDA regulations, GCP requirements and their protocols in order for the data to be considered reliable for regulatory purposes. Progress reports detailing the results of the clinical trials must be submitted at least annually to the FDA and more frequently if serious adverse events occur. Phase 1, Phase 2 and Phase 3 clinical trials may not be completed successfully within any specified period, or at all. Government regulation may delay or prevent marketing of product candidates or new drugs for a considerable period of time and impose costly procedures upon our activities. Disclosure of Clinical Trial Information Sponsors of clinical trials of FDA- regulated products, including drugs, are required to register and disclose certain clinical trial information. Information related to the product, patient population, phase of investigation, study sites and investigators, and other aspects of the clinical trial is then made public as part of the registration. Sponsors are also obligated to disclose the results of their clinical trials after completion. Disclosure of the results of these trials can be delayed until the new product or new indication being studied has been approved up to a maximum of two years. Competitors may use this publicly available information to gain knowledge regarding the progress of development programs. The BLA Approval Process In order to obtain approval to market a drug in the U. S., a marketing application must be submitted to the FDA that provides data establishing to the FDA' s satisfaction the safety and effectiveness of the investigational drug for the proposed indication. The application includes all relevant data available from pertinent non- clinical or preclinical studies and clinical trials, including negative or ambiguous results as well as positive findings, together with detailed information relating to the product' s chemistry, manufacturing, controls and proposed labeling, among other things. Data can come from company- sponsored clinical trials intended to test the safety and effectiveness of a use of a product, or from a number of alternative sources, including studies initiated by investigators that meet GCP requirements. During the development of a new drug, sponsors are given opportunities to meet with the FDA at certain points. These points may be prior to submission of an IND **application** , at the End- of- Phase 1 or 2, and before a BLA is submitted. Meetings at other times may be requested. These meetings can provide an opportunity for the sponsor to share information about the data gathered to date, for the FDA to provide advice and for the sponsor and the FDA to reach agreement on the next phase of development. The results of product development, non- clinical studies and clinical trials, along with descriptions of the manufacturing process, analytical tests conducted on the chemistry of the drug, proposed labeling and other relevant information are submitted to the FDA as part of a BLA requesting approval to market the product for its intended indication. The FDA reviews all BLAs submitted to ensure that they are sufficiently complete for substantive review before it accepts them for filing. It may request additional information rather than accept a BLA for filing. In this event, the BLA must be resubmitted with the additional **requested** information. The resubmitted application also is subject to review before the FDA accepts it for filing. The FDA has 60 days from its receipt of a BLA to conduct an initial review to determine whether the application will be accepted for filing based on the agency' s threshold determination that the application is sufficiently complete to permit substantive review. The FDA reviews a BLA to determine, among other things, whether the proposed product is safe and potent, or effective, for its intended use, and has an acceptable purity profile, and whether the product is being manufactured in accordance with cGMP to assure and preserve the product' s identity, safety, strength, quality, potency and purity. The FDA has agreed to specific performance goals on the review of BLA' s. Specifically, ~~FDA~~ under the goals and policies agreed to by the FDA under the Prescription Drug User Fee Act, or PDUFA, as amended, the FDA has 10 months, from the filing date, in which to complete its initial review of an original BLA and respond to the applicant, and six months from the filing date of an original BLA designated for priority review. The review process may be extended by the FDA for three additional months to consider certain late- submitted information or information intended to clarify information already provided in the submission. After the FDA completes its substantive review of a BLA, it will communicate to the sponsor that the drug will either be approved, or it will issue a complete response letter to communicate that the BLA will not be approved in its current form and inform the sponsor of changes that must be made or additional clinical, non- clinical or manufacturing data that must be received before the application can be approved, with no implication regarding the ultimate approvability of the application or the timing of any such approval, if ever. If or when those deficiencies have been addressed to the FDA' s satisfaction in a resubmission of the BLA, the FDA may issue an approval letter: **The** FDA has

committed to reviewing such resubmissions in two to six months depending on the type of information included. The FDA may refer applications for novel drug products or drug products that present difficult questions of safety or efficacy to an advisory committee, typically a panel that includes clinicians and other experts, for review, evaluation, and a recommendation as to whether the application should be approved and, if so, under what conditions. The FDA is not bound by the recommendations of an advisory committee, but it considers such recommendations carefully when making decisions. Before approving a BLA, the FDA typically will inspect the facilities at which the product is manufactured. The FDA will not approve the product unless it determines that the manufacturing processes and facilities are in compliance with cGMP requirements and **are** adequate to assure consistent production of the product within required specifications. Additionally, before approving a BLA, the FDA may inspect one or more clinical sites to assure compliance with GCP. For a gene therapy product, the FDA also will not approve the product if the manufacturer is not in compliance with ~~the~~ cGTPs. These are FDA regulations that govern the methods used in, and the facilities and controls used for, the manufacture of human cells, tissues, and cellular and tissue- based products, or HCT / Ps, which are human cells or tissue intended for implantation, transplant, infusion, or transfer into a human recipient. The primary intent of the cGTP requirements is to ensure that cell and tissue- based products are manufactured in a manner designed to prevent the introduction, transmission and spread of communicable disease. FDA regulations also require tissue establishments to register and list their HCT / Ps with the FDA and, when applicable, to evaluate donors through appropriate screening and testing. If the FDA determines that the application, manufacturing process or manufacturing facilities are not acceptable, it typically will outline the deficiencies and often will request additional testing or information. This may significantly delay further review of the application. If the FDA finds that a clinical site did not conduct the clinical trial in accordance with GCP, the FDA may determine the data generated by the clinical site should be excluded from the primary efficacy analyses provided in the BLA. Additionally, notwithstanding the submission of any requested additional information, the FDA ultimately may decide that the application does not satisfy the regulatory criteria for approval. The FDA may require, or companies may pursue, additional clinical trials after a product is approved. These so- called Phase 4 or post- approval trials may be made a condition to be satisfied for continuing drug approval. The results of Phase 4 trials can confirm the effectiveness of a product candidate and can provide important safety information. In addition, the FDA has authority to require sponsors to conduct post- marketing trials to specifically address safety issues identified by the agency. See “ Post- Marketing Requirements ” below. The FDA also has authority to require a Risk Evaluation and Mitigation Strategy, or REMS, from manufacturers to ensure that the benefits of a drug outweigh its risks. A sponsor may also voluntarily propose a REMS as part of the BLA submission. The need for a REMS is determined as part of the review of the BLA. Based on statutory standards, elements of a REMS may include “ Dear Doctor letters, ” a medication guide, more elaborate targeted educational programs, and in some cases distribution and use restrictions, referred to as elements to assure safe use, or ETASU. ETASU can include, but are not limited to, special training or certification for prescribing or dispensing, dispensing only under certain circumstances, special monitoring and the use of patient registries. These elements are negotiated as part of the BLA approval, and in some cases the approval date may be delayed. Once adopted, REMS are subject to periodic assessment and modification. Changes to some of the conditions established in an approved application, including changes in indications, labeling, manufacturing processes or facilities, require submission and FDA approval of a new BLA or BLA supplement before the change can be implemented. A BLA supplement for a new indication typically requires clinical data similar to that in the original application, and the FDA uses the same procedures and actions in reviewing BLA supplements as it does in reviewing BLAs. Even if a product candidate receives regulatory approval, the approval may be limited to specific disease states, patient populations and dosages, or might contain significant limitations on use in the form of warnings, precautions or contraindications, or in the form of onerous risk management plans, restrictions on distribution or use, or post- marketing trial requirements. Further, even after regulatory approval is obtained, later discovery of previously unknown problems with a product may result in restrictions on the product, including safety labeling or imposition of a REMS, the requirement to conduct post- market studies or clinical trials or even complete withdrawal of the product from the market. Delay in obtaining, or failure to obtain, regulatory approval for our products, or obtaining approval but for significantly limited use, would harm our business. In addition, we cannot predict what adverse governmental regulations may arise from future U. S. or foreign governmental action. The Hatch- Waxman Amendments Under the Drug Price Competition and Patent Term Restoration Act of 1984, referred to as the Hatch- Waxman Amendments, a portion of a product’ s U. S. patent term that was lost during clinical development and regulatory review by the FDA may be restored by returning up to five years of patent life for a patent that covers a new product or its use. This period is generally one- half the time between the effective date of an IND **application** (falling after issuance of the patent) and the submission date of a BLA, plus the time between the submission date of a BLA and the approval of that application, provided that the sponsor acted with diligence. Patent term restorations, however, cannot extend the remaining term of a patent beyond a total of 14 years from the date of product approval and only one patent applicable to an approved drug may be extended and the extension must be applied for prior to expiration of the patent. The U. S. Patent and Trademark Office, in consultation with the FDA, reviews and approves the application for any patent term extension or restoration. Market Exclusivity The Patient Protection and Affordable Care Act, as amended by the Health Care Education and Reconciliation Act, or, collectively, the ACA, signed into law on March 23, 2010, includes a subtitle called the Biologics Price Competition and Innovation Act of 2009, or the BPCIA, which created an abbreviated approval pathway for biological products shown to be similar to, or interchangeable with, an FDA- approved reference biological product. Bio similarity, which requires that there be no clinically meaningful differences between the biological product and the reference product in terms of safety, purity, and potency, can be shown through analytical studies, animal studies, and a clinical trial or trials. Interchangeability requires that a product is biosimilar to the reference product and the product must demonstrate that it can be expected to produce the same clinical results as the reference product and, for products administered multiple times, the biologic and the reference biologic may be switched after one has been previously administered without increasing safety risks or risks of diminished efficacy relative to exclusive

use of the reference biologic. However, complexities associated with the larger, and often more complex, structure of biological products, as well as the process by which such products are manufactured, pose significant hurdles to implementation that are still being worked out by the FDA. A reference biological product is granted four ~~(4)~~ and ~~twelve (12)~~ year exclusivity periods from the time of first licensure of the product. FDA will not accept an application for a biosimilar or interchangeable product based on the reference biological product until four years after the date of first licensure of the reference product, and FDA will not approve an application for a biosimilar or interchangeable product based on the reference biological product until ~~twelve (12)~~ years after the date of first licensure of the reference product. “ First licensure ” typically means the initial date the particular product at issue was approved in the ~~United States~~ **U. S.** Date of first licensure does not include the date of licensure of (and a new period of exclusivity is not available for) a biological product if the licensure is for a supplement for the biological product or for a subsequent application by the same sponsor or manufacturer of the biological product (or licensor, predecessor in interest, or other related entity) for a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device or strength, or for a modification to the structure of the biological product that does not result in a change in safety, purity, or potency. Therefore, one must determine whether a new product includes a modification to the structure of a previously approved product that results in a change in safety, purity, or potency to assess whether the licensure of the new product is a first licensure that triggers its own period of exclusivity. Whether a subsequent application, if approved, warrants exclusivity as the “ first licensure ” of a biological product is determined on a case- by- case basis with data submitted by the sponsor. In addition, under the Orphan Drug Act, **the** FDA may designate a biologic product as an “ orphan drug ” if it is intended to treat a rare disease or condition (generally meaning that it affects fewer than 200, 000 individuals in the U. S., or more in cases in which there is no reasonable expectation that the cost of developing and making a biologic product available in the U. S. for treatment of the disease or condition will be recovered from sales of the product). Orphan product designation must be requested before submitting a BLA. After FDA grants orphan product designation, the identity of the therapeutic agent and its potential orphan use are disclosed publicly by FDA. Orphan product designation does not convey any advantage in, or shorten the duration of, the regulatory review and approval process. If a product with orphan status receives the first FDA approval for the disease or condition for which it has such designation, the product is entitled to orphan product exclusivity, meaning that **the** FDA may not approve any other applications to market the same drug or biologic product for the same indication for seven years, except in limited circumstances, such as a showing of clinical superiority to the product with orphan exclusivity or if the party holding the exclusivity fails to assure the availability of sufficient quantities of the drug to meet the needs of patients with the disease or condition for which the drug was designated. Competitors, however, may receive approval of different products for the same indication than that for which the orphan product has exclusivity or obtain approval for the same product but for a different indication for which the orphan product has exclusivity. Orphan medicinal product status in the EU has similar, but not identical, benefits. Pediatric exclusivity is another type of non- patent marketing exclusivity in the U. S. and, if granted, provides for the attachment of an additional six months of marketing protection to the term of any existing regulatory exclusivity **periods for all formulations, including dosage forms, and indications of the biologic non- patent exclusivity.** This six- month exclusivity may be granted if a BLA sponsor submits pediatric data that fairly respond to a written request from the FDA for such data. Rare Pediatric Disease Designation and Priority Review Vouchers Under the FDCA, the FDA incentivizes the development of drugs and biological products that meet the definition of a “ rare pediatric disease, ” defined to mean a serious or life- threatening disease in which the serious of life- threatening manifestations primarily affect individuals aged from birth to 18 years and the disease affects fewer than 200, 000 individuals in the ~~United States~~ **U. S.** or affects more than 200, 000 in the ~~United States~~ **U. S.** and for which there is no reasonable expectation that the cost of developing and making in the ~~United States~~ **U. S.** a drug or biological product for such disease or condition will be recovered from sales in the ~~United States~~ **U. S.** of such drug or biological product. The sponsor of a product candidate for a rare pediatric disease may be eligible for a voucher that can be used to obtain a priority review for a subsequent human drug or biological product application after the date of approval of the rare pediatric disease drug or biological product, referred to as a priority review voucher, or PRV. A sponsor may request rare pediatric disease designation from the FDA prior to the submission of its BLA. A rare pediatric disease designation does not guarantee that a sponsor will receive a PRV upon approval of its BLA. Moreover, a sponsor who chooses not to submit a rare pediatric disease designation request may nonetheless receive a PRV upon approval of their marketing application if they request such a voucher in their original marketing application and meet all of the eligibility criteria. If a PRV is received, it may be sold or transferred an unlimited number of times. Congress has extended the PRV program through September 30, 2024, with the potential for PRVs to be granted through September 30, 2026. Expedited Development and Review Programs **The** FDA is authorized to expedite the review of BLAs in several ways. Under the Fast Track program, the sponsor of a biologic product candidate may request **the** FDA to designate the product for a specific indication as a Fast Track product concurrent with or after the filing of the IND **application**. Biologic products are eligible for Fast Track designation if they are intended to treat a serious or life- threatening condition and demonstrate the potential to address unmet medical needs for the condition. Fast Track designation applies to the combination of the product candidate and the specific indication for which it is being studied. In addition to other benefits, such as the ability to have greater interactions with **the** FDA, **the** FDA may initiate review of sections of a Fast ~~–~~Track BLA before the application is complete, a process known as rolling review. Any product submitted to **the** FDA for marketing, including under a Fast Track program, may be eligible for other types of FDA programs intended to expedite development and review, such as regenerative medicine advanced therapy, or RMAT, designation, priority review and accelerated approval. To qualify for RMAT designation, the product candidate must be a regenerative medicine therapy, which is defined as a cell therapy, therapeutic tissue engineering product, human cell and tissue product, or any combination product using such therapies or products, except for those regulated solely under Section 361 of the Public Health Service Act and part 1271 of Title 21 ~~, of the~~ Code of Federal Regulations; is intended to

treat, modify, reverse, or cure a serious or life- threatening disease or condition; and preliminary clinical evidence indicates that the product has the potential to address unmet medical needs for such disease or condition. A gene therapy product may meet the definition of a regenerative medicine therapy for purposes of RMAT designation. A BLA for a product candidate that has received RMAT designation may be eligible for priority review or accelerated approval through use of surrogate or intermediate endpoints reasonably likely to predict long- term clinical benefit, or reliance upon data obtained from a meaningful number of sites. Benefits of RMAT designation also include early interactions with **the** FDA to discuss any potential surrogate or intermediate endpoint to be used to support accelerated approval. A product candidate with RMAT designation that is granted accelerated approval and is subject to post- approval requirements may fulfill such requirements through the submission of clinical evidence from clinical studies, patient registries, or other sources of real- world evidence, such as electronic health records; the collection of larger confirmatory data sets; or post- approval monitoring of all patients treated with such therapy prior to its approval. A product candidate including one that received Fast Track or RMAT designation is eligible for priority review if it treats a serious condition and, if approved, it would be a significant improvement in the safety or effectiveness of the treatment, diagnosis or prevention of a serious condition compared to available therapies. **The** FDA aims to complete its review of priority review applications within six months **as opposed of the filing date, compared** to 10 months for standard review. Additionally, a biologic product may be eligible for accelerated approval if it is designed to treat a serious or life- threatening disease or condition and demonstrates an effect on a surrogate endpoint that is reasonably likely to predict a clinical benefit, or on the basis of an effect on a clinical endpoint other than survival or irreversible morbidity or mortality or other clinical benefit, taking into account the severity, rarity and prevalence of the condition and the availability or lack of alternative treatments. As a condition of approval, **the** FDA may require that a sponsor of a drug or biologic product candidate receiving accelerated approval perform adequate and well- controlled post- marketing clinical trials and, under the Food and Drug Omnibus Reform Act of 2022, or FDORA, the FDA is now permitted to require, as appropriate, that such trials be underway prior to approval or within a specific time period after the date of approval for a product granted accelerated approval. Under FDORA, the FDA has increased authority for expedited procedures to withdraw approval of a drug or indication approved under accelerated approval if, for example, the confirmatory trial fails to verify the predicted clinical benefit of the product. In addition, **the** FDA currently requires, unless otherwise informed by the agency, pre- approval of promotional materials intended for dissemination or publication. Even if a product qualifies for one or more of these programs, the FDA may later decide that the product no longer meets the conditions for qualification or the time period for FDA review or approval may not be shortened. Fast Track designation, priority review and accelerated approval do not change the standards for approval but may expedite the development or approval process. Additionally, under FDORA, a platform technology incorporated within or utilized by a biological product is eligible for designation as a designated platform technology if (1) the platform technology is incorporated in, or utilized by, a biological product approved under a BLA; (2) preliminary evidence submitted by the sponsor of the licensed biological product, or a sponsor that has been granted a right of reference to data submitted in the application for such biological product, demonstrates that the platform technology has the potential to be incorporated in, or utilized by, more than one biological product without an adverse effect on quality, manufacturing, or safety; and (3) data or information submitted by the applicable person indicates that incorporation or utilization of the platform technology has a reasonable likelihood to bring significant efficiencies to the biological product development or manufacturing process and to the review process. A sponsor may request the FDA to designate a platform technology as a designated platform technology concurrently with, or at any time after, submission of an IND application for a biological product that incorporates or utilizes the platform technology that is the subject of the request. If so designated, the FDA may expedite the development and review of any subsequent original BLA for a biological product that uses or incorporates the platform technology. Designated platform technology status does not ensure that a biological product will be developed more quickly or receive FDA approval. In addition, the FDA may revoke a designation if the FDA determines that a designated platform technology no longer meets the criteria for such designation. Following approval of a new product, a pharmaceutical company and the approved product are subject to continuing regulation by the FDA, including, among other things, monitoring and recordkeeping activities, reporting to the applicable regulatory authorities of adverse experiences with the product, providing the regulatory authorities with updated safety and efficacy information, product sampling and distribution requirements, and complying with promotion and advertising requirements, which include, among others, standards for direct- to- consumer advertising, restrictions on promoting drugs for uses or in patient populations that are not described in the drug' s approved labeling, or off- label use, limitations on industry- sponsored scientific and educational activities and requirements for promotional activities involving the internet. Although physicians may, in their independent professional medical judgment, prescribe legally available drugs for off- label uses, manufacturers typically may not market or promote such off- label uses. Modifications or enhancements to the product or its labeling or changes of the site of manufacture are often subject to the approval of the FDA and other regulators, who may or may not grant approval or may include a lengthy review process. Prescription drug advertising is subject to federal, state, and foreign regulations. In the U. S., the FDA regulates prescription drug promotion, including direct- to- consumer advertising. Prescription drug promotional materials must be submitted to the FDA in conjunction with their first use. Any distribution of prescription drug products and pharmaceutical samples must comply with the U. S. Prescription Drug Marketing Act, a part of the FDCA. In the U. S., once a product is approved, its manufacturing is subject to comprehensive and continuing regulation by the FDA. The FDA regulations require that products be manufactured in specific approved facilities and in accordance with cGMP. cGMP regulations require among other things, quality control and quality assurance as well as the corresponding maintenance of records and documentation and the obligation to investigate and correct any deviations from cGMP. Drug manufacturers and other entities involved in the manufacture and distribution of approved drugs are required to register their establishments with the FDA and certain state agencies and are subject to periodic unannounced inspections by the FDA and certain state agencies for compliance with cGMP and other laws. Additionally, manufacturers and other parties involved in the

supply chain for prescription drug products must also comply with product tracking and tracing requirements and for notifying the FDA of counterfeit, diverted, stolen and intentionally adulterated products or products that are otherwise unfit for distribution in the U. S. Accordingly, manufacturers must continue to expend time, money, and effort in the area of production and quality control to maintain cGMP compliance. These regulations also impose certain organizational, procedural and documentation requirements with respect to manufacturing and quality assurance activities. BLA holders using contract manufacturers, laboratories or packagers are responsible for the selection and monitoring of qualified firms, and, in certain circumstances, qualified suppliers to these firms. These firms and, where applicable, their suppliers are subject to inspections by the FDA at any time, and the discovery of violative conditions, including failure to conform to cGMP, could result in enforcement actions that interrupt the operation of any such product or may result in restrictions on a product, manufacturer, or holder of an approved BLA, including, among other things, recall or withdrawal of the product from the market. In addition, the manufacturer and / or holder of an approved BLA are subject to annual product and establishment fees. These fees are typically increased annually. The FDA also may require post- marketing testing, also known as Phase 4 testing, to monitor the effects of an approved product or place conditions on an approval via a REMS that could restrict the distribution or use of the product. Discovery of previously unknown problems with a product or the failure to comply with applicable FDA requirements can have negative consequences, including adverse publicity, judicial or administrative enforcement, untitled or warning letters from the FDA, mandated corrective advertising or communications with doctors, withdrawal of approval, and civil or criminal penalties, among others. Newly discovered or developed safety or effectiveness data may require changes to a product' s approved labeling, including the addition of new warnings and contraindications, and also may require the implementation of other risk management measures. Also, new government requirements, including those resulting from new legislation, may be established, or the FDA' s policies may change, which could delay or prevent regulatory approval of our products under development. Coverage and Reimbursement Sales of any products for which we receive regulatory approval for commercial sale will depend in part on the availability of reimbursement from third- party payors, including government healthcare program administrative authorities, managed care organizations, private health insurers, and other entities. Patients who are prescribed medications for the treatment of their conditions, and their prescribing physicians, generally rely on third- party payors to reimburse all **of or** part of the costs associated with their prescription drugs. Patients are unlikely to use our products unless coverage is provided, and reimbursement is adequate to cover a significant portion of the cost of our products. Therefore, our products, once approved, may not obtain market acceptance unless coverage is provided, and reimbursement is adequate to cover a significant portion of the cost of our products. ~~Factors payors consider in determining reimbursement are based on whether the product is: • a covered benefit under its health plan; • safe, effective and medically necessary; • appropriate for the specific patient; • cost- effective; and • neither experimental nor investigational.~~ In the U. S., no uniform policy of coverage and reimbursement for drug or biological products exists. The process for determining whether a third- party payor will provide coverage for a drug product typically is separate from the process for setting the price of a drug product or for establishing the reimbursement rate that the payor will pay for the drug product once coverage is approved. Third- party payors may limit coverage to specific drug products on an approved list, also known as a formulary, which might not include all of the FDA- approved drugs for a particular indication. A decision by a third- party payor not to cover our product candidates could reduce physician utilization of our products once approved. Moreover, a third- party payor' s decision to provide coverage for a drug product does not imply that an adequate reimbursement rate will be approved. Adequate third- party reimbursement may not be available to enable us to maintain price levels sufficient to realize an appropriate return on our investment in product development. Additionally, coverage and reimbursement for drug products can differ significantly from payor to payor. One third- party payor' s decision to cover a particular drug product or service does not ensure that other payors will also provide coverage for the medical product or service or will provide coverage at an adequate reimbursement rate. As a result, the coverage determination process will require us to provide scientific and clinical support for the use of our products to each payor separately and will be a time- consuming process. The containment of healthcare costs has become a priority of federal, state, and foreign governments, and the prices of drugs have been a focus in this effort. Third- party payors are increasingly challenging the prices charged for drug products and medical services, examining the medical necessity, and reviewing the cost effectiveness of drug products and medical services, in addition to questioning safety and efficacy. If these third- party payors do not consider our products to be cost- effective compared to other available therapies, they may not cover our products after FDA approval or, if they do, the level of payment may not be sufficient to allow us to sell our products at a profit. The American Recovery and Reinvestment Act of 2009 provided funding for the federal government to compare the effectiveness of different treatments for the same illness. The plan for the research was published in 2012 by the Department of Health and Human Services, the Agency for Healthcare Research and Quality and the National Institutes for Health, and periodic reports on the status of the research and related expenditures will be made to Congress. Although the results of the comparative effectiveness studies are not intended to mandate coverage policies for public or private payors, it is not clear what effect, if any, the research will have on the sales of our product candidates, if any such product or the condition that it is intended to treat is the subject of a study. It is also possible that comparative effectiveness research demonstrating benefits in a competitor' s product could adversely affect the sales of our product candidates, once approved. If third- party payors do not consider our products to be cost- effective compared to other available therapies, they may not cover our products after approval as a benefit under their plans or, if they do, the level of payment may not be sufficient to allow us to sell our products on a profitable basis. In addition, in some foreign countries, the proposed pricing for a drug must be approved before it may be lawfully marketed. The requirements governing drug pricing vary widely from country to country. For example, the EU provides options for its member states to restrict the range of medicinal products for which their national health insurance systems provide reimbursement and to control the prices of medicinal products for human use. A member state may approve a specific price for the medicinal product, or it may instead adopt a system of direct or indirect controls on the profitability of the company placing the medicinal product on the market.

There can be no assurance that any country that has price controls or reimbursement limitations for pharmaceutical products will allow favorable reimbursement and pricing arrangements for any of our products. Historically, products launched in the EU do not follow price structures of the U. S. and generally tend to be significantly lower. Anti- Kickback and False Claims Laws and Other Regulatory Matters In the U. S., among other things, the research, manufacturing, distribution, sale and promotion of drug products and medical devices are potentially subject to regulation and enforcement by various federal, state and local authorities in addition to the FDA, including the Centers for Medicare & Medicaid Services, other divisions of the U. S. Department of Health and Human Services (HHS) (e. g., the Office of Inspector General), the Drug Enforcement Administration, the Consumer Product Safety Commission, the Federal Trade Commission, the Occupational Safety & Health Administration, the Environmental Protection Agency, state Attorneys General and other state and local government agencies. Our current and future business activities, including for example, sales, marketing, and scientific / educational grant programs must comply with healthcare regulatory laws, as applicable, which may include the Federal Anti- Kickback Statute, the Federal False Claims Act, as amended, the privacy and security regulations promulgated under the Health Insurance Portability and Accountability Act, or HIPAA, as amended, physician payment transparency laws, and similar state laws. Pricing and rebate programs must comply with the Medicaid Drug Rebate Program requirements of the Omnibus Budget Reconciliation Act of 1990, as amended, and the Veterans Health Care Act of 1992, as amended. If products are made available to authorized users of the Federal Supply Schedule of the General Services Administration, additional laws and requirements apply. All of these activities are also potentially subject to federal and state consumer protection and unfair competition laws. The distribution of pharmaceutical products is subject to additional requirements and regulations, including extensive record- keeping, licensing, storage, and security requirements intended to prevent the unauthorized sale of pharmaceutical products. The Federal Anti- Kickback Statute makes it illegal for any person or entity, including a prescription drug manufacturer (or a party acting on its behalf) to knowingly and willfully, directly or indirectly, in cash or in kind, solicit, receive, offer, or pay any remuneration that is intended to induce the referral of business, including the purchasing, leasing, ordering or arranging for or recommending the purchase, lease or order of, any good, facility, item or service for which payment may be made, in whole or in part, under a federal healthcare program, such as Medicare or Medicaid. The term “ remuneration ” has been broadly interpreted to include anything of value. The Federal Anti- Kickback Statute has been interpreted to apply to arrangements between pharmaceutical manufacturers on one hand and prescribers, purchasers, and formulary managers on the other. Although there are a number of statutory exceptions and regulatory safe harbors protecting some common activities from prosecution, the exceptions and safe harbors are drawn narrowly. Practices that involve remuneration that may be alleged to be intended to induce prescribing, purchases or recommendations may be subject to scrutiny if they do not qualify for an exception or safe harbor. Failure to meet all of the requirements of a particular applicable statutory exception or regulatory safe harbor does not make the conduct per se illegal under the Federal Anti- Kickback Statute. Instead, the legality of the arrangement will be evaluated on a case- by- case basis based on a cumulative review of all of its facts and circumstances. Additionally, the intent standard under the Federal Anti- Kickback Statute was amended by the ACA to a stricter standard such that a person or entity no longer needs to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation. In addition, the ACA codified case law that a claim including items or services resulting from a violation of the Federal Anti- Kickback Statute constitutes a false or fraudulent claim for purposes of the Federal False Claims Act. Violations of this law are punishable by up to five years in prison, criminal fines, administrative civil money penalties, and exclusion from participation in federal healthcare programs. In addition, many states have adopted laws similar to the Federal Anti- Kickback Statute. Some of these state prohibitions apply to the referral of patients for healthcare services reimbursed by any insurer, not just federal healthcare programs such as Medicare and Medicaid. Due to the breadth of these federal and state anti- kickback laws, and the potential for additional legal or regulatory change in this area, it is possible that our future business activities, including our sales and marketing practices and / or our future relationships with physicians and the medical community might be challenged under anti- kickback laws, which could harm us. Federal false claims and false statement laws, including the civil False Claims Act, prohibits any person or entity from, among other things, knowingly presenting, or causing to be presented, for payment to federal programs (including Medicare and Medicaid) claims for items or services, including drugs, that are false or fraudulent. Although we would not submit claims directly to payors, manufacturers can be held liable under these laws if they are deemed to “ cause ” the submission of false or fraudulent claims by, for example, providing inaccurate billing or coding information to customers or promoting a product off- label. In addition, our future activities relating to the reporting of wholesaler or estimated retail prices for our products, the reporting of prices used to calculate Medicaid rebate information and other information affecting federal, state, and third- party reimbursement for our products, and the sale and marketing of our products, are subject to scrutiny under this law. For example, pharmaceutical companies have been found liable under the Federal Civil False Claims Act in connection with their off- label promotion of drugs. Penalties for a civil False Claims Act violation include three times the actual damages sustained by the government, plus mandatory civil penalties for each separate false claim, the potential for exclusion from participation in federal healthcare programs, and, although the Federal False Claims Act is a civil statute, conduct that results in a False Claims Act violation may also implicate various federal criminal statutes. If the government were to allege that we were, or convict us of, violating these false claims laws, we could be subject to a substantial fine and may suffer a decline in our stock price. In addition, private individuals have the ability to bring actions under the Federal Civil False Claims Act and certain states have enacted laws modeled after the Federal False Claims Act. Additionally, HIPAA created additional federal criminal statutes that prohibit, among other things, knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program, including private third- party payors and knowingly and willfully falsifying, concealing, or covering up a material fact or making any materially false, fictitious, or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. Similar to the federal Anti- Kickback Statute, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation. There are also an

increasing number of state laws that require manufacturers to make reports to states on pricing and marketing information. Many of these laws contain ambiguities as to what is required to comply with the laws. For example, federal government price reporting laws, which require us to calculate and report complex pricing metrics in an accurate and timely manner to government programs. In addition, as discussed below, a similar federal requirement under the Physician Payments Sunshine Act, requires certain manufacturers to track and report to the federal government certain payments provided to physicians, certain other licensed health care practitioners and teaching hospitals made in the previous calendar year, as well as certain ownership and investment interests held by physicians (defined to include doctors, dentists, optometrists, podiatrists, and chiropractors) and their immediate family members. These laws may affect our sales, marketing, and other promotional activities by imposing administrative and compliance burdens on us. In addition, given the lack of clarity with respect to these laws and their implementation, our reporting actions could be subject to the penalty provisions of the pertinent state and federal authorities. Further, we may be subject to data privacy and security regulation by both the federal government and the states in which we conduct our business. HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act, or HITECH, and their respective implementing regulations, including the Final Omnibus Rule published on January 25, 2013, imposes specified requirements relating to the privacy, security, and transmission of individually identifiable health information on certain types of individuals and organizations. HITECH also created new tiers of civil monetary penalties, amended HIPAA to make civil and criminal penalties directly applicable to business associates, and gave state attorneys general new authority to file civil actions for damages or injunctions in federal courts to enforce the federal HIPAA laws and seek attorneys' fees and costs associated with pursuing federal civil actions. In addition, there may be other federal, state and non- U. S. laws which govern the privacy and security of health and other personal information in certain circumstances, many of which differ from each other and from HIPAA in significant ways and may not have the same effect, thus complicating compliance efforts. The failure to comply with regulatory requirements subjects us to possible legal or regulatory action. Depending on the circumstances, failure to meet applicable regulatory requirements can result in significant criminal, civil and / or administrative penalties, damages, fines, disgorgement, exclusion from participation in federal healthcare programs, such as Medicare and Medicaid, injunctions, recall or seizure of products, total or partial suspension of production, denial or withdrawal of product approvals, refusal to allow us to enter into supply contracts, including government contracts, contractual damages, reputational harm, administrative burdens, diminished profits and future earnings, and the curtailment or restructuring of our operations, any of which could adversely affect our ability to operate our business and our results of operations. We plan to develop a comprehensive compliance program that establishes internal controls to facilitate adherence to the law and program requirements to which we will or may become subject because we intend to commercialize products that could be reimbursed under a federal healthcare program and other governmental healthcare programs. Changes in law or the interpretation of existing law could impact our business in the future by requiring, for example: (i) changes to our manufacturing arrangements; (ii) additions or modifications to product labeling; (iii) the recall or discontinuation of our products; or (iv) additional record-keeping requirements. If any such changes were to be imposed, they could adversely affect the operation of our business.

Healthcare Legislative Reform In both the **United States U. S.** and certain foreign jurisdictions, there have been a number of legislative and regulatory changes to the health care system that could impact our ability to sell our products profitably. In particular, in 2010, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, or collectively, the ACA, was enacted, which, among other things, subjected biologic products to potential competition by lower- cost biosimilars; increased the minimum Medicaid rebates owed by most manufacturers under the Medicaid Drug Rebate Program; extended the Medicaid Drug Rebate program to utilization of prescriptions of individuals enrolled in Medicaid managed care organizations; subjected manufacturers to new annual fees and taxes for certain branded prescription drugs; created a new Medicare Part D coverage gap discount program, in which manufacturers must agree to offer 70 % point- of- sale discounts off negotiated prices of applicable brand drugs to eligible beneficiaries during their coverage gap period, as a condition for the manufacturer' s outpatient drugs to be covered under Medicare Part D; and provided incentives to programs that increase the federal government' s comparative effectiveness research. Other legislative changes have been proposed and adopted since the ACA was enacted. • The Budget Control Act of 2011, which, among other things, created measures for spending reductions by Congress. This includes aggregate reductions of Medicare payments to providers of 2 % per fiscal year. Subsequent legislation extended the 2 % reduction which remains in effect through 2031. Due to the Statutory Pay- As- You- Go Act of 2010, estimated budget deficit increases resulting from the American Rescue Plan Act of 2021, and subsequent legislation, Medicare payments to providers will be further reduced starting in 2025 absent further legislation. • The American Taxpayer Relief Act of 2012, among other things, reduced Medicare payments to several providers and increased the statute of limitations period for the government to recover overpayments to providers from three to five years. • On April 13, 2017, CMS published a final rule that gives states greater flexibility in setting benchmarks for insurers in the individual and small group marketplaces, which may have the effect of relaxing the essential health benefits required under the ACA for plans sold through such marketplaces. • On May 30, 2018, the Right to Try Act, was signed into law. The law, among other things, provides a federal framework for certain patients to access certain investigational new drug products that have completed a Phase 1 clinical trial and that are undergoing investigation for FDA approval. Under certain circumstances, eligible patients can seek treatment without enrolling in clinical trials and without obtaining FDA permission under the FDA expanded access program. There is no obligation for a pharmaceutical manufacturer to make its drug products available to eligible patients as a result of the Right to Try Act. • On May 23, 2019, CMS published a final rule to allow Medicare Advantage Plans the option of using step therapy for Part B drugs beginning January 1, 2020. There has been increasing legislative and enforcement interest in the **United States U. S.** with respect to specialty drug pricing practices. Specifically, there have been several recent U. S. Congressional inquiries and proposed federal and state legislation designed to, among other things, bring more transparency to drug pricing, reduce the cost of prescription drugs under Medicare, review the relationship between pricing and manufacturer

patient programs, and reform government program reimbursement methodologies for drugs. **On the federal level,** President Biden has issued multiple executive orders that have sought to reduce prescription drug costs. **In February 2023, HHS also issued a proposal in response to an October 2022 executive order from President Biden that includes a proposed prescription drug pricing model that will test whether targeted Medicare payment adjustments will sufficiently incentivize manufacturers to complete confirmatory trials for drugs approved through the FDA's accelerated approval pathway.** Although a number of these and other proposed measures may require authorization through additional legislation to become effective, and the Biden administration may reverse or otherwise change these measures, both the Biden administration and Congress have indicated that they will continue to seek new legislative measures to control drug costs. The Inflation Reduction Act of 2022 (~~or IRA~~) includes several provisions that ~~will may~~ impact our business to varying degrees, including provisions that ~~reduce the~~ **create a \$2,000 out-of-pocket spending cap for Medicare Part D beneficiaries from \$7,050 to \$2,000 starting in 2025, thereby effectively eliminating the coverage gap;** impose new manufacturer financial liability on ~~at~~ **certain drugs in under** Medicare Part D, allow the U. S. government to negotiate Medicare Part B and Part D ~~pricing price~~ **caps** for certain high-cost drugs and biologics without generic or biosimilar competition; require companies to pay rebates to Medicare for ~~certain~~ drug prices that increase faster than inflation; and delay ~~until January 1, 2032~~ **the implementation of the HHS rebate rule that would require pass-through of** ~~have limited the fees that~~ **pharmacy benefit manager-managers can charge rebates to beneficiaries.** Further, under the IRA, orphan drugs are exempted from the Medicare drug price negotiation program, but only if they have one ~~orphan rare disease~~ **orphan rare disease** designation and for which the only approved indication is for that disease or condition. If a product receives multiple ~~orphan rare disease~~ designations or has multiple approved indications, it may not qualify for the orphan drug exemption. **The implementation of the IRA is currently subject to ongoing litigation challenging the constitutionality of the IRA's Medicare drug price negotiation program. The outcome of these challenges on the IRA, and the effect effects of the IRA on our business and the healthcare industry in general is are** not yet known. ~~In addition, there have been several changes to the 340B drug pricing program, which imposes ceilings on prices that drug manufacturers can charge for medications sold to certain health care facilities. On December 27, 2018, the District Court for the District of Columbia invalidated a reimbursement formula change under the 340B drug pricing program, and CMS subsequently altered the FYs 2019 and 2018 reimbursement formula on specified covered outpatient drugs, or SCODs. The court ruled this change was not an "adjustment" which was within the Secretary's discretion to make but was instead a fundamental change in the reimbursement calculation. However, most recently, on July 31, 2020, the U. S. Court of Appeals for the District of Columbia Circuit overturned the district court's decision and found that the changes were within the Secretary's authority. On September 14, 2020, the plaintiffs-appellees filed a Petition for Rehearing En Banc (i. e., before the full court), but was denied on October 16, 2020. Plaintiffs-appellees filed a petition for a writ of certiorari at the Supreme Court on February 10, 2021, and the petition was granted on July 2, 2021. On June 15, 2022, the Supreme Court unanimously reversed the Court of Appeals' decision, holding that HHS's 2018 and 2019 reimbursement rates for 340B hospitals were contrary to the statute and unlawful. Although a number of these, and other proposed measures will require authorization through additional legislation to become effective, Congress has indicated that it may continue to seek new legislative and/or administrative measures to control drug costs.~~ At the state level, legislatures have increasingly passed legislation and implemented regulations designed to control pharmaceutical and biological product pricing, including price or patient reimbursement constraints, discounts, restrictions on certain product access and marketing cost disclosure and transparency measures, and, in some cases, designed to encourage importation from other countries and bulk purchasing. We expect that the healthcare reform measures that have been adopted and may be adopted in the future, may result in more rigorous coverage criteria and in additional downward pressure on the price that we receive for any approved product and could seriously harm our future revenues. Any reduction in reimbursement from Medicare or other government programs may result in a similar reduction in payments from private third-party payors. There have been, and likely will continue to be, legislative and regulatory proposals at the foreign, federal, and state levels directed at broadening the availability of healthcare and containing or lowering the cost of healthcare. The implementation of cost containment measures or other healthcare reforms may prevent us from being able to generate revenue, attain profitability, or commercialize our ~~product~~ **products**. Such reforms could have an adverse effect on anticipated revenue from product candidates that we may successfully develop and for which we may obtain regulatory approval and may affect our overall financial condition and ability to develop product candidates. European Union Drug Review and Approval Clinical Trial Approval In the EU, an applicant for authorization of a clinical trial must obtain prior approval from the national competent authority of the EU Member States in which the clinical trial is to be conducted. Furthermore, the applicant may only start a clinical trial at a specific study site after the relevant independent ethics committee has issued a favorable opinion. In April 2014, the EU adopted the ~~new~~ **Clinical Trials Regulation (EU) No 536 / 2014**, which replaced the Clinical Trials Directive 2001 / 20 / EC on January 31, 2022. It overhauls the system of approvals for clinical trials in the EU. Specifically, the new legislation, which is directly applicable in all EU Member States (meaning that no national implementing legislation in each EU Member State is required), aims at simplifying and streamlining the approval of clinical trials in the EU. For instance, the ~~new~~ **Clinical Trials Regulation** provides for a streamlined application procedure via a single-entry point (instead of submitting applications separately to each national competent authority and ethics committee in the Member States in which the trial will be conducted) and strictly defined deadlines for the assessment of clinical trial applications. The Clinical Trials Regulation also makes it more efficient for EU Member States to evaluate and authorize applications together, via the Clinical Trials Information System. The transitory provisions of the ~~new~~ **Clinical Trials Regulation provide that, by January 31, 2025, all ongoing offer sponsors the possibility to choose between the requirements of the previous Clinical clinical Trials trials Directive and must have transitioned to** the Clinical Trials Regulation if the request for authorization of a clinical trial is submitted in the year after the new Clinical Trials Regulation became applicable. If the sponsor chooses to submit under the Clinical Trials Directive, the clinical trial continues to be governed by the Directive until three years after the new Clinical Trials Regulation became

applicable. If a clinical trial continues for more than three years after the Clinical Trials Regulation became applicable, the Clinical Trials Regulation will at that time begin to apply to the clinical trial. Marketing Authorization In the EU European Union, medicinal products can only be commercialized after obtaining a marketing authorization. There are two types of marketing authorizations: (1) the centralized authorization, which is issued by the European Commission through the centralized procedure based on the opinion of the Committee for Medicinal Products for Human Use, or CHMP, a body of the EMA, and which is valid throughout the entire territory of the European Economic Area, or EEA (comprising the EU Member States plus Norway, Iceland and Liechtenstein); and (2) national marketing authorizations, which ~~is~~ **are** issued by the competent authorities of the Member States of the EU and only authorize marketing in that Member State's national territory and not the EEA as a whole. The centralized procedure is mandatory for certain types of products, such as biotechnology medicinal products, orphan medicinal products, advanced therapy medicinal products (i. e., gene- therapy, somatic cell- therapy, and tissue- engineered medicines) and medicinal products containing a new active substance indicated for the treatment of HIV / AIDS, cancer, neurodegenerative disorders, diabetes, ~~auto-immune~~ **autoimmune diseases disorders** and other immune dysfunctions and viral diseases. The centralized procedure is optional for products containing a new active substance not yet authorized in the EU, or for products that constitute a significant therapeutic, scientific, or technical innovation or which are in the interest of public health. ~~Gene therapy products are a type of advanced therapy medicinal product, or ATMP, in the EU. The EMA is responsible for the~~ scientific evaluation of marketing authorization applications ~~in~~ **for** ATMPs is primarily performed by a specialized scientific committee called the Committee for Advanced Therapies, or CAT. The CAT prepares a draft opinion on the quality, safety, and efficacy of the ATMP which is the subject of the marketing authorization application, which is sent for final approval to the CHMP. The CHMP recommendation is then ~~the centralized procedure~~ sent to the European Commission, which adopts a decision binding in all EEA Member States. The maximum timeframe for the evaluation of a marketing authorization application ~~for an ATMP by the EMA~~ is 210 days from receipt of a valid application, excluding clock stops when additional information or written or oral explanation is to be provided by the applicant in response to questions of the ~~CAT and/or~~ CHMP. Clock stops may extend the timeframe of evaluation of an application considerably beyond 210 days. Where the CHMP gives a positive opinion, the EMA provides the opinion together with supporting documentation to the European Commission, who ~~make~~ **makes** the final decision to grant a marketing authorization, which is issued within 67 days of receipt of the EMA's recommendation. Accelerated assessment may be granted by the CHMP in exceptional cases, when a medicinal product is of major interest from the point of view of public health and, in particular, from the viewpoint of therapeutic innovation. If the CHMP accepts such a request, the timeframe of 210 days for assessment will be reduced to 150 days (excluding clock stops), but it is possible that the CHMP may revert to the standard time limit for the centralized procedure if it determines that the application is no longer appropriate to conduct an accelerated assessment. ~~The development and evaluation of a gene therapy medicinal product must be considered in the context of the relevant EU guidelines, and the EMA may issue new guidelines concerning the development and marketing authorization for gene therapy medicinal products and require that we comply with these new guidelines.~~ National marketing authorizations are for products not falling within the mandatory scope of the centralized procedure. Where a product has already been authorized for marketing in a Member State of the EU, this marketing authorization can be recognized in another Member ~~States-~~ **State** through the mutual recognition procedure. If the product has not received a national marketing authorization in any Member State at the time of application, it can be approved simultaneously in various Member States through the decentralized procedure. Under the decentralized procedure an identical dossier is submitted to the competent authorities of each of the Member States in which an authorization is sought, one of which is selected by the applicant as the Reference Member State, or RMS. If the RMS proposes to authorize the product, and the other Member States do not raise objections, the product is granted a national marketing authorization in all the Member States where the authorization was sought. Under the above- described procedures, before granting the **MAA marketing authorization**, the EMA or the competent authorities of the Member States of the EU make an assessment of the risk- benefit balance of the product on the basis of scientific criteria concerning its quality, safety, and efficacy. Now that the UK (which comprises Great Britain and Northern Ireland) has left the EU, Great Britain ~~will is~~ no longer be covered by centralized marketing authorizations (under the Northern Ireland Protocol, centralized marketing authorizations ~~will~~ **currently** continue to be recognized in Northern Ireland). ~~On All medicinal products with a current centralized marketing authorization were automatically converted to Great Britain marketing authorizations on January 1, 2021-2024.~~ For a period of two years from January 1, 2021, ~~a new international recognition framework was put in place by~~ the Medicines and Healthcare products Regulatory Agency, or MHRA, the UK medicines regulator, ~~under which the MHRA may rely have regard to decisions on a decision taken the approval of marketing authorizations made by the European Commission on EMA and certain the other approval of regulators when considering an application for~~ a new marketing authorization in the centralized procedure, in order to more quickly grant a new Great Britain marketing authorization. ~~A separate application will, however, still be required.~~ Regulatory exclusivity In the EU, innovative products authorized for marketing (i. e., reference products) may qualify for eight years of data exclusivity and an additional two years of market exclusivity upon marketing authorization. The data exclusivity period prevents generic or biosimilar applicants from relying on the preclinical and clinical trial data contained in the dossier of the reference product when applying for a generic or biosimilar marketing authorization in the EU during a period of eight years from the date on which the reference product was first authorized in the EU. The market exclusivity period prevents a successful generic or biosimilar applicant from commercializing its product in the EU until ten years have elapsed from the initial authorization of the reference product. The ten- year market exclusivity period can be extended to a maximum of ~~eleven~~ **11** years if, during the first eight years of those ten years, the marketing authorization holder obtains an authorization for one or more new therapeutic indications which, during the scientific evaluation prior to their authorization, are held to bring a significant clinical benefit in comparison with existing therapies. Even if an innovative medicinal product gains the prescribed period of data exclusivity, however, another company may market another version of the product if such company obtained

marketing authorization based on a marketing authorization application with a ~~completely~~ **complete and** independent data package of pharmaceutical tests, preclinical tests, and clinical trials. Orphan designation and exclusivity The criteria for designating an orphan medicinal product in the EU ~~are~~ similar in principle to those in the U. S. Under ~~Article 3 of Regulation (EC) No 141 / 2000~~ **Article 3 of Regulation (EC) No 141 / 2000**, a medicinal product may be designated as **an orphan product** if the following criteria are fulfilled: (i) it is intended for the diagnosis, prevention or treatment of a life- threatening or chronically debilitating condition; (ii) either (a) such condition affects no more than five in 10, 000 persons in the EU when the application is made, or (b) the product, without the benefits derived from orphan status, would not generate sufficient return in the EU to justify the necessary investment in its development; and (iii) there exists no satisfactory method of diagnosis, prevention or treatment of such condition authorized for marketing in the EU, or if such a method exists, the product will be of significant benefit to those affected by the condition, as defined in Regulation (EC) No 847 / 2000. Orphan medicinal products are eligible for financial incentives such as reduction of fees or fee waivers and are, upon grant of a marketing authorization, entitled to ten years of market exclusivity for the approved therapeutic indication. The application for orphan designation must be submitted before the application for marketing authorization. The applicant will receive a fee reduction for the marketing authorization application if the orphan designation has been granted, but not if the designation is still pending at the time the marketing authorization is submitted. Orphan designation does not convey any advantage in, or shorten the duration of, the regulatory review and approval process. The ten- year market exclusivity **period** may be reduced to six years if, at the end of the fifth year, it is established that the product no longer meets the criteria for orphan designation, for example, if the product is sufficiently profitable not to justify maintenance of market exclusivity. Otherwise, **during the period of market exclusivity, a marketing authorization may only be granted in the EU to a “ similar medicinal product ” to the authorized orphan product for the same therapeutic indication** ~~medicine marketing exclusivity may be revoked only in very select cases, such as if:~~ • a second applicant can establish that its product, although similar to the authorized **orphan** product, is safer, more effective, or otherwise clinically superior; • the marketing authorization holder for the authorized **orphan** product consents to a second orphan medicinal product application; or • the marketing authorization holder for the authorized **orphan** product cannot supply enough orphan medicinal product. ~~The aforementioned EU rules are generally applicable.~~ **A “ similar medicinal product ” is defined as a medicinal product containing a similar active substance or substances as contained in an authorized orphan medicinal product, and which is intended for the same therapeutic indication.** PRIME designation In March 2016, the EMA launched an initiative to facilitate development of product candidates in indications, often rare, for which few or no therapies currently exist. The PRiority Medicines, or PRIME, scheme is intended to encourage **drug product** development in areas of unmet medical need and provides accelerated assessment of products representing substantial innovation, where the marketing authorization application will be made through the centralized procedure. Eligible products must target conditions for which ~~where there~~ is an unmet medical need ~~(i. e., there is no satisfactory method of diagnosis, prevention or treatment in the EU or, if there is, the new medicine will bring a major therapeutic advantage)~~ and they must show potential to benefit patients with unmet medical needs based on early clinical data. Products from small- and medium- sized enterprises may qualify for earlier entry into the PRIME scheme than larger companies. Many benefits accrue to sponsors of product candidates with PRIME designation, including but not limited to, early and proactive regulatory dialogue with the EMA, frequent discussions on clinical trial designs and other development program elements, and accelerated marketing authorization application assessment once a dossier has been submitted. Importantly, a dedicated contact and rapporteur from the EMA’ s CHMP or Committee for Advanced Therapies are appointed early in PRIME scheme facilitating increased understanding of the product at the EMA’ s committee level. A kick- off meeting initiates these relationships and includes a team of multidisciplinary experts at the EMA to provide guidance on the overall development and regulatory strategies. Where, during the course of development, a medicine no longer meets the eligibility criteria, support under the PRIME scheme may be withdrawn. ~~Brexit and~~ **The aforementioned EU rules are generally applicable in the EEA. Reform of the Regulatory Framework in the European Union The European Commission introduced legislative proposals in April 2023 that, if implemented, will replace the current regulatory framework in the EU for all medicines (including those for rare diseases and for children). The European Commission has provided the legislative proposals to the European Parliament and the European Council for their review and approval. In October 2023, the European Parliament published draft reports proposing amendments to the legislative proposals, which will be debated by the European Parliament. Once the European Commission’ s legislative proposals are approved (with or without amendment), they will be adopted into EU law. Brexit and the Regulatory Framework in the United Kingdom** ~~The~~ In June 2016, the electorate in the UK voted in favor of leaving the EU, or commonly referred to as Brexit, and the UK formally left the EU on January 31, 2020 ~~. There was a transition period during which EU pharmaceutical laws continued to apply to the UK, and which expired on December 31, 2020. However,~~ the EU and the UK have concluded a trade and cooperation agreement, or TCA, which was provisionally applicable since January 1, 2021 and has been formally applicable since May 1, 2021. The TCA includes specific provisions concerning pharmaceuticals, which include the mutual recognition of GMP, inspections of manufacturing facilities for medicinal products and GMP documents issued but does not ~~foresee~~ **provide for** wholesale mutual recognition of UK and EU pharmaceutical regulations. At present, Great Britain has implemented EU legislation on the marketing, promotion and sale of medicinal products through the Human Medicines Regulations 2012 (as amended) (under the Northern Ireland Protocol, the EU regulatory framework ~~will currently continue~~ **continues** to apply in Northern Ireland). The regulatory regime in Great Britain therefore largely aligns with current EU regulations, however it is possible that these regimes will diverge in **the** future now that Great Britain’ s regulatory system is independent from the EU and the TCA does not provide for mutual recognition of UK and EU pharmaceutical legislation. For example, the **EU Clinical Trials Regulation does not apply in the UK** ~~has implemented~~ **and the current UK clinical trials legislation is based on** the now repealed Clinical Trials Directive 2001 / 20 / EC ~~into national law through the Medicines for Human Use (Clinical Trials) Regulations 2004 (as amended).~~ The extent to which the regulation of clinical trials in the UK will mirror the new Clinical

Trials Regulation now that has come into effect is not yet known, however **However** the Medicines and Healthcare products Regulatory Agency, or **the MHRA published details**, the UK medicines regulator, opened a consultation on a set of **its legislative** proposals designed to improve and strengthen the UK clinical trials legislation **on March 21, 2023**. Such **The legislative proposals were published in response to a** consultation was open until **which ran from January 17, 2022 to March 14, 2022**. The MHRA will now work with lawyers to draft such new legislation. **Notwithstanding that there is no wholesale recognition of EU pharmaceutical legislation under the TCA, under a new framework mentioned above which was put in place by the MHRA on January 1, 2024, the MHRA may take into account decisions on the approval of marketing authorizations from the EMA (and certain other regulators) when considering an application for a Great Britain marketing authorizations. On February 27, 2023, the UK government and the European Commission announced a political agreement in principle to replace the Northern Ireland Protocol with a new set of arrangements, known as the "Windsor Framework". This new framework fundamentally changes the existing system under the Northern Ireland Protocol, including with respect to the regulation of medicinal products in the UK. In particular, the MHRA will be responsible for approving all medicinal products destined for the UK market (Great Britain and Northern Ireland), and the EMA will no longer have any role in approving medicinal products destined for Northern Ireland. A single UK-wide marketing authorization will be granted by the MHRA for all medicinal products to be sold in the UK, enabling products to be sold in a single pack and under a single authorization throughout the UK. The Windsor Framework was approved by the EU- UK Joint Committee on March 24, 2023, so the UK government and the EU will enact legislative measures to bring it into law. On June 9, 2023, the MHRA announced that the medicines aspects of the Windsor Framework will apply from January 1, 2025.**

The Foreign Corrupt Practices Act The Foreign Corrupt Practices Act, or the FCPA, prohibits any U. S. individual or business from paying, offering, or authorizing payment or offering of anything of value, directly or indirectly, to any foreign official, political party or candidate for the purpose of influencing any act or decision of the foreign entity in order to assist the individual or business in obtaining or retaining business. The FCPA also obligates companies whose securities are listed in the **United States U. S.** to comply with accounting provisions requiring us to maintain books and records that accurately and fairly reflect all transactions of the corporation, including international subsidiaries, and to devise and maintain an adequate system of internal accounting controls for international operations. Additional Regulation In addition to the foregoing, state and federal laws regarding environmental protection and hazardous substances, including the Occupational Safety and Health Act, the Resource Conservancy and Recovery Act and the Toxic Substances Control Act, affect our business. These and other laws govern our use, handling and disposal of various biological, chemical and radioactive substances used in, and wastes generated by, our operations. If our operations result in contamination of the environment or expose individuals to hazardous substances, we could be liable for damages and governmental fines. We believe that we are in material compliance with applicable environmental laws and that continued compliance therewith will not have a material adverse effect on our business. We cannot predict, however, how changes in these laws may affect our future operations. Other Regulations We are also subject to numerous federal, state and local laws relating to such matters as safe working conditions, manufacturing practices, environmental protection, fire hazard control, and disposal of hazardous or potentially hazardous substances. We may incur significant costs to comply with such laws and regulations now or in the future. Human Capital As of **February 28 March 1, 2023-2024**, we had **137-154** full-time employees and **1-0** part-time **employee-employees**. 39 of whom have Ph. D. or M. D. degrees. Of these full-time employees, **105-121** employees are engaged in research and development activities and **32-33** are engaged in finance, business development and other general and administrative functions. None of our employees are represented by labor unions or covered by collective bargaining agreements, and we have not experienced any work stoppages. We consider our relations with our employees to be good. We recognize that attracting, motivating and retaining talent at all levels is vital to our continued success. Our employees are a significant asset, and we aim to create an equitable, inclusive and empowering environment in which our employees can grow and advance their careers, with the overall goal of developing, expanding and retaining our workforce to support our current pipeline and future business goals. By focusing on employee retention and engagement, we also improve our ability to support our clinical trials, our pipeline, our platform technologies, business and operations, and also protect the long-term interests of our securityholders. Our success also depends on our ability to attract, engage and retain a diverse group of employees. Our efforts to recruit and retain a diverse and passionate workforce include providing competitive compensation and benefits packages and ensuring we listen to our employees. We value innovation, passion, data-driven decision making, persistence and honesty, and are building a diverse environment where our employees can thrive and be inspired to make exceptional contributions to bring novel and more effective therapies to cancer patients. Our human capital resources objectives include, as applicable, identifying, recruiting, retaining, motivating and integrating our existing and future employees. The principal purposes of our equity incentive plans are to attract, retain and motivate selected employees, consultants and directors through grants of stock-based compensation awards and payments of cash-based performance bonus awards, in order to increase stockholder value and the success of our company by motivating our employees to perform to the best of their abilities and achieve our objectives. We are committed to providing a competitive and comprehensive benefits package to our employees. Our benefits package provides a balance of protection along with the flexibility to meet the individual health and wellness needs of our employees. We plan to continue to refine our efforts related to optimizing our use of human capital as we grow, including improvements in the way we hire, develop, motivate and retain employees. Facilities Our corporate headquarters is located at 830 Winter Street in Waltham, Massachusetts. The facility at 830 Winter Street is 25,472 square feet of laboratory space, with a lease expiration of **September-October 2024-2029**. We also lease a facility at 880 Winter Street which is 113,487 square feet of office and laboratory space with a lease termination date of December 2032. We believe that these facilities are adequate to meet our needs for the immediate future, and that, should it be needed, suitable additional space will be available to accommodate any such expansion of our operations. Legal Proceedings We are not currently a party to any material legal proceedings. From time to time, we may become involved in legal proceedings

arising in the ordinary course of our business. Regardless of outcome, litigation can have an adverse impact on us due to defense and settlement costs, diversion of management resources, negative publicity, reputational harm and other factors. Available Information Our website address is <https://www.tscan.com/>. The information contained on, or that can be accessed through, our website is not incorporated by reference into this Annual Report on Form 10-K or in any other report or document we have filed or may file with the Securities and Exchange Commission, or SEC, and any reference to our website address is intended to be an inactive textual reference only. We will make available on our website, free of charge, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and any amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains an Internet site, <http://www.sec.gov>, containing reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC. In addition, we routinely post on the “Investors and Media” page of our website investor and scientific presentations, SEC filings, press releases, public conference calls and webcasts and other statements about our business and results of operations, some of which may contain information that may be deemed material to investors. Accordingly, investors should monitor these portions of our website, in addition to following our press releases, SEC filings, public conference calls and webcasts, as well as our social media channels (our Twitter and LinkedIn). This list of channels may be updated from time to time on our investor relations website and may include other social media channels than the ones described above. The contents of our website or these channels, or any other website that may be accessed from our website or these channels, shall not be deemed incorporated by reference in any filing under the Securities Act of 1933, as amended. A copy of our Corporate Governance Guidelines, and Code of Conduct are posted on our website, <https://www.tscan.com> and are available in print to any person who requests copies by contacting us by calling (857) 399-9500 or by writing to TScan Therapeutics, Inc., 830 Winter Street, Waltham, Massachusetts 02451, Attention: Zoran Zdraveski. Item 1A. Risk Factors –Our business involves a high degree of risk. You should carefully consider the material and other risks and uncertainties described and summarized below, as well as the other information in this Annual Report on Form 10-K, including our consolidated financial statements and related notes and the section titled “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and “Special Note Regarding Forward-Looking Statements,” as well as our other filings with the SEC, before you make an investment decision. Our actual results could differ materially from those anticipated in the forward-looking statements as a result of factors that are described below and elsewhere in this Annual Report on Form 10-K. The risks described below are not the only risks that we face. The occurrence of any of the events or developments described below could materially and adversely affect our business, financial condition, results of operations and prospects. As a result, the market price of our common stock could decline, and you may lose all or part of your investment in our common stock. RISK FACTORS Investment in biopharmaceutical product development is a highly speculative undertaking and entails substantial upfront capital expenditures and significant risk that any potential product candidate will fail to demonstrate adequate efficacy or an acceptable safety profile, gain regulatory approval and become commercially viable. We are still in the early stages of development of our product candidates and have only recently initiated clinical studies/trials for certain of our product candidates TSC-100 and TSC-101. We have no products licensed for commercial sale and have not generated any revenue from product sales to date, and we continue to incur significant research and development and other expenses related to our ongoing operations. We have financed our operations primarily through private placements of our preferred stock, our initial public offering offerings in 2021 and 2023, borrowings under a secured loan agreement in September 2022 and upfront payments under our existing or previous collaborations. We have incurred significant net losses in each period since our inception in April 2018. For the years ended December 31, 2020, 2023, 2022 and 2021, we reported net losses of \$ 26.89, 1.2 million, \$ 66.2 million and \$ 48.6 million, respectively, and \$ 18. As of 7 million and \$ 66.2 million for the three and twelve months ended December 31, 2022-2023, respectively. As of December 31, 2022, we had an accumulated deficit of \$ 158.247. 4-6 million. We expect to continue to incur significant losses for the foreseeable future, and we expect these losses to increase substantially if and as we: • continue our research and development efforts to identify and develop lead product candidates and submit additional IND investigational new drug applications, or INDs, for such lead product candidates; • conduct preclinical studies and commence clinical trials for our current and future product candidates based on our proprietary platform; • develop processes suitable for manufacturing and clinical development ; • continue to develop and expand our manufacturing capabilities; • seek marketing approvals for any of our product candidates that successfully complete clinical trials; • build commercial infrastructure to support sales and marketing for our product candidates; • expand, maintain and protect our intellectual property portfolio; • hire additional clinical, regulatory and scientific personnel; and • continue to operate as a public company. Because of the numerous risks and uncertainties associated with biopharmaceutical product research and development, we are unable to accurately predict the timing or amount of the increased expenses we will incur or when, if ever, we will be able to achieve profitability. Even if we succeed in commercializing one or more of our product candidates, we will continue to incur substantial research and development expenses and other expenditures to develop, seek regulatory approval for, and market additional product candidates. We may encounter unforeseen expenses, difficulties, complications, delays and other unknown factors that may adversely affect our business. The size of our future net losses will depend, in part, on the rate of future growth of our expenses and our ability to generate revenue. Our prior losses and expected future losses have had and will continue to have an adverse effect on our stockholders’ equity and working capital. Our success depends on our ability to use our proprietary platform (i) to discover the natural targets of clinically relevant TCRs through our TargetScan technology, (ii) to discover highly active TCRs for known targets through our ReceptorScan technology, (iii) to genetically engineer patient- or donor- derived T cells safely and reproducibly through our T- Integrate technology, (iv) to obtain regulatory approval for product candidates derived from our proprietary platform and related technologies, and (v) to then commercialize our product candidates that address one or more indications. All of our product candidates will require significant additional clinical and non-clinical development, review and approval by the U. S. Food and

Drug Administration, or FDA, or other regulatory authorities in one or more jurisdictions, substantial investment, access to sufficient commercial manufacturing capacity and significant marketing efforts before they can be successfully commercialized. Our proprietary platform and our product candidates **are currently being** ~~have not yet been~~ evaluated in humans and may never become commercialized. Moreover, all of our current product candidates are being developed using our proprietary platform and leveraging the same or similar technology, manufacturing process and development program. As a result, an issue with one product candidate or failure of any one program to obtain regulatory approval could adversely impact our ability to successfully develop and commercialize all of our other product candidates. In addition, the success of our proprietary platform in discovering novel targets for TCR- **Ts T** therapy is dependent on us obtaining tumor samples from cancer patients who actively respond to cancer immunotherapies. If our ability to obtain a significant amount of such tumor samples in a timely manner is compromised due to unforeseen circumstances, we may not be successful in discovering novel targets and creating new product candidates based on such targets. ~~Our limited operating history may make it difficult to evaluate the success of our business to date and to assess our future viability.~~ We are a clinical- stage biopharmaceutical company with a limited operating history. We commenced operations in April 2018, and our operations to date have been limited to organizing and staffing our **company** **Company**, business planning, raising capital, conducting discovery and research activities, filing patent applications, identifying potential product candidates, undertaking preclinical studies, entering into licenses and collaborations, establishing manufacturing for initial quantities of our product candidates, and establishing arrangements for component materials for such manufacturing. Although we have initiated clinical trials for certain of our product candidates, we have not yet demonstrated our ability to successfully conduct or complete any clinical trials, obtain marketing approvals, manufacture clinical or commercial-scale product or arrange for a third party to do so on our behalf, or conduct sales, marketing and distribution activities necessary for successful product commercialization. Consequently, any predictions about our future success or viability may not be as accurate as they could be if we had a longer operating history. In addition, as a young business, we may encounter unforeseen expenses, difficulties, complications, delays and other known and unknown factors. We eventually may need to transition at some point from a company with a research and development focus to a company capable of supporting commercial activities. We may not be successful in such a transition. We expect our financial condition and operating results to continue to fluctuate significantly from quarter to quarter and year to year due to a variety of factors, many of which are beyond our control. Accordingly, the results of any quarterly or annual periods should not be relied upon as indications of future operating performance. We have never generated any revenue from sales of cell ~~–~~therapy products and our ability to generate revenue from cell ~~–~~therapy product sales and become profitable depends significantly on our success in a number of areas. Our ability to become profitable depends upon our ability to generate revenue. To date, we have not generated any revenue from sales of any of our product candidates. We do not expect to generate significant revenue unless or until we successfully complete clinical development and obtain regulatory approval of, and then successfully commercialize, at least one of our product candidates. Although we have initiated clinical trials for certain of our product candidates, we have not yet demonstrated an ability to successfully complete clinical trials of our product candidates, obtain marketing approvals, manufacture a commercial- scale medicine, or arrange for a third party to do so on our behalf, or conduct sales and marketing activities necessary for successful commercialization to enable us to generate any revenue from product sales. Our other product candidates are in **early various stages of** ~~preclinical development~~ **stages.** ~~We have not yet administered any of our product candidates in humans~~ and, as such, we face significant translational risk as ~~our~~ **we work to advance these** ~~product candidates~~ **advance** to the clinical stage. Our ability to generate revenue depends on a number of factors, including, but not limited to: • our ability to develop processes suitable for clinical manufacturing and to obtain related chemistry, manufacturing, and controls ~~(, or CMC,)~~ regulatory approvals; • timely completion of our preclinical studies and clinical trials, which may be significantly slower or cost more than we currently anticipate and will depend substantially upon the performance of third ~~-~~ party contractors; • our ability to continue to complete IND- enabling studies and to continue to successfully submit ~~INDs~~ **IND** or comparable applications; • whether we are required by the ~~U. S. Food and Drug Administration (FDA)~~ or similar foreign regulatory authorities to conduct additional clinical trials or other studies beyond those planned to support the approval and commercialization of our product candidates or any future product candidates; • our ability to demonstrate to the satisfaction of the FDA and similar foreign regulatory authorities the safety, potency, purity and acceptable risk to benefit profile of our product candidates or any future product candidates; • the prevalence, duration and severity of potential side effects or other safety issues, including adverse events, experienced with our product candidates or future product candidates, if any; • the timely receipt of necessary marketing approvals from the FDA and similar foreign regulatory authorities; • the willingness of physicians, operators of clinics and patients to utilize or adopt any of **our** product candidates or future product candidates to treat hematologic malignancies or solid tumors; • our ability and the ability of our third ~~parties~~ **party** contractors to manufacture adequate clinical and commercial supplies of our product candidates or any future product candidates, remain in good standing with regulatory authorities and develop, validate and maintain commercially viable manufacturing processes that are compliant with **current good manufacturing practices, or cGMP**; • our ability to successfully develop a commercial strategy and thereafter commercialize our product candidates or any future product candidates in the ~~United States~~ **U. S.** and internationally, if licensed for marketing, reimbursement, sale and distribution in such countries and territories, whether alone or in collaboration with others; • patient demand for our product candidates and any future product candidates, if licensed; and • our ability to establish, obtain, maintain, protect and enforce intellectual property and proprietary rights in and to our product candidates or any future product candidates. Many of the factors listed above are beyond our control ~~–~~ and could cause us to experience significant delays or prevent us from obtaining regulatory approvals or commercializing our product candidates. Even if we are able to commercialize our product candidates, we may not achieve profitability soon after generating product sales, if ever. If we are unable to generate sufficient revenue through the sale of our product candidates or any future product candidates, we may be unable to continue operations without continued funding. ~~We will need to obtain substantial additional funding to complete the development and any~~

commercialization of our product candidates, if approved. If we are unable to raise this necessary capital when needed, we would be forced to delay, reduce or eliminate our product development programs, commercialization efforts or other operations. Since our inception, we have financed our operations through private placements of preferred stock ~~;~~ through our initial public offering ~~offerings~~ ~~;~~ **upfront payments under our collaborations** and through our debt financing facility. The development of biopharmaceutical product candidates is capital intensive and we expect our expenses to increase substantially during the next few years. As our product candidates enter and advance through preclinical studies and clinical trials, we will need substantial additional funds to expand our clinical, regulatory, quality and manufacturing capabilities. In addition, if we obtain marketing approval for any of our product candidates, we expect to incur significant commercialization expenses related to marketing, sales, manufacturing and distribution. Furthermore, we expect to incur additional costs associated with operating as a public company. As of December 31, ~~2022~~ **2023**, we had \$ ~~120~~ **192**. 0 million in cash ~~and~~ cash equivalents ~~and marketable securities~~. Based on our current operating plan, we believe that our existing cash ~~and~~ cash equivalents ~~and marketable securities~~ will be sufficient to fund our operating expenses and capital expenditure requirements into ~~the second quarter of 2024~~ **2026**. Accordingly, our existing cash ~~and~~ cash equivalents ~~and marketable securities~~ will not be sufficient for us to fund any of our product candidates through regulatory approval, and we will need to raise substantial additional capital to complete the development and commercialization of our product candidates through equity offerings, debt financings, marketing and distribution arrangements and other collaborations, strategic alliances and licensing arrangements or other sources. We may also need to raise additional funds sooner if we choose to pursue additional indications for our product candidates or otherwise expand more rapidly than we presently anticipate. We have based these estimates on assumptions that may prove to be incorrect or require adjustment as a result of business decisions, and we could utilize our available capital resources sooner than we currently expect. Our future capital requirements will depend on many factors, including: • the scope, rate of progress, costs and results of our drug discovery, preclinical ~~or clinical~~ development activities, laboratory testing and clinical trials for our product candidates; • the number and scope of clinical programs we decide to pursue; • the scope and costs of manufacturing development and commercial manufacturing activities and our ability to scale them up or out; • the extent to which we acquire or in-license other product candidates and technologies; • the cost, timing and outcome of regulatory review of our product candidates, including the potential for regulatory authorities to require that we conduct more studies and trials than those that we currently expect to conduct and the costs of post-marketing studies or risk evaluation and mitigation strategies that could be required by regulatory authorities; • potential changes in the regulatory environment and enforcement rules; • the cost and timing of establishing sales and marketing capabilities, if any of our product candidates receive marketing approval; • the costs of preparing, filing and prosecuting patent applications, maintaining, obtaining, protecting and enforcing our intellectual property and proprietary rights and defending intellectual property-related claims; • our ability to establish ~~new~~ and maintain ~~existing licensing or collaborations~~ ~~–~~ **collaboration on favorable terms, if at all** ~~arrangements and the progress of the development efforts of third parties with whom we may enter into such arrangements~~; • ~~the any continuing~~ impact of ~~public health crises~~ ~~the COVID-19 pandemic~~ or other external disruptions on our business, results of operations, ~~development plans (including any supply related matters)~~ and financial position; • our efforts to enhance operational systems and our ability to attract, hire and retain qualified personnel, including personnel to support the development of our product candidates; • potential changes in pharmaceutical pricing and reimbursement infrastructure; • the costs associated with being a public company; and • the cost associated with commercializing our product candidates, if they receive marketing approval. Identifying potential product candidates and conducting preclinical studies and clinical trials is a time consuming, expensive and uncertain process that takes years to complete, and we may never generate the necessary data or results required to obtain marketing approval. In addition, our product candidates, if approved, may not achieve product sales or commercial success. We do not expect to have any products commercially available for sale for many years, if at all. Accordingly, we will need to obtain substantial additional funding in connection with our continuing operations. Adequate additional financing may not be available to us on acceptable terms, or at all, and may be impacted by the economic climate and market conditions. If we are unable to raise capital when needed or on attractive terms, we would be forced to delay, limit, reduce or eliminate our research and development programs or future commercialization efforts or grant rights to develop and market product candidates that we would otherwise prefer to develop and market ourselves. In addition, attempting to secure additional financing may divert the time and attention of management from day-to-day activities and distract from our research and development efforts. We may also seek additional capital due to favorable market conditions or strategic considerations, even if we believe we have sufficient funds for our current or future operating plans. ~~Raising additional capital may cause dilution to our existing stockholders, restrict our operations or require us to relinquish rights to our intellectual property or product candidates on unfavorable terms to us.~~ We may seek additional capital through a variety of means, including through collaboration arrangements, public or private equity or debt financings, third ~~party~~ (including government) funding and marketing and distribution arrangements, as well as other strategic alliances and licensing arrangements or any combination of these approaches. However, there can be no assurance that we will be able to raise capital on commercially reasonable terms or at all. To the extent that we raise additional capital through the sale of equity or convertible debt securities, our stockholder ownership interest will be diluted, and the terms may include liquidation preferences or other rights, powers or preferences that may adversely affect rights of our stockholders. To the extent that debt financing is available, ~~and~~ we choose to raise additional capital in the form of debt, such debt financing may involve agreements that include covenants limiting or restricting our ability to take certain actions, such as incurring additional debt, making capital expenditures or declaring dividends. If we raise additional capital pursuant to collaborations, licensing arrangements or other strategic partnerships, such agreements may require us to relinquish rights to our technologies or product candidates. If we are unable to raise additional funds through equity or debt financing or through collaborations, licensing arrangements or strategic partnerships when needed, we may be required to delay, limit, reduce or terminate our product development or commercialization efforts. Our ability to raise capital is subject to the risk of adverse changes in the

market value of our stock. Periods of macroeconomic weakness or recession and heightened market volatility caused by adverse geopolitical developments could increase these risks, potentially resulting in adverse impacts on our ability to raise further capital on favorable terms. The impact of geopolitical tension, such as a deterioration in the bilateral relationship between the **US-U. S.** and China or in the ongoing **conflict** **conflicts** between Russia and Ukraine **or between Israel and Hamas**, including resulting sanctions, export controls or other restrictive actions that may be imposed by the **US-U. S.** and / or other countries against governmental or other entities in, for example, Russia, also could lead to disruption, instability and volatility in global trade patterns, which may in turn impact our ability to source necessary reagents, raw materials and other inputs for our research and development operations. Any of the abovementioned factors could affect our business, prospects, financial condition, and operating results. The extent and duration of any political instability and resulting market disruptions are impossible to predict ; but could be substantial. Any such disruptions may also have the effect of heightening many of the other risks and uncertainties described elsewhere in this “ Risk Factors ” section. Our operations consume substantial amounts of cash, and we intend to continue to make significant investments to support our business growth, respond to business challenges or opportunities, develop new products, retain or expand our current levels of personnel, support our programs, enhance our operating infrastructure, and potentially acquire complementary businesses and technologies. Our future capital requirements may be significantly different from our current estimates and will depend on many factors, including the need to: • finance unanticipated working capital requirements, including clinical manufacturing capacity; • support our discovery and preclinical development activities, and clinical trials for our product candidates; • pursue acquisitions or other strategic relationships; and • respond to competitive pressures. Accordingly, we may need to pursue equity or debt financings to meet our capital needs. With uncertainty in the capital markets and other factors, such financing may not be available on terms favorable to us or at all. If we raise additional funds through further issuances of equity or convertible debt securities, our existing stockholders could suffer significant dilution, and any new equity securities we issue could have rights, preferences, and privileges superior to those of holders of our common stock. Any debt financing secured by us in the future could involve additional restrictive covenants relating to our capital- raising activities and other financial and operational matters, which may make it more difficult for us to obtain additional capital and to pursue business opportunities, including potential acquisitions. If we are unable to obtain adequate financing or financing on terms satisfactory to us, we could face significant limitations on our ability to invest in our operations and otherwise suffer harm to our business. **Actual events involving limited liquidity, defaults, non- performance or other adverse developments that affect financial institutions, transactional counterparties or other companies in the financial services industry or the financial services industry generally, or concerns or rumors about any events of these kinds or other similar risks, have in the past and may in the future lead to market- wide liquidity problems. For example, on March 10, 2023, Silicon Valley Bank (SVB) was closed by the California Department of Financial Protection and Innovation, which appointed the Federal Deposit Insurance Corporation (FDIC) as receiver. Similarly, on March 12, 2023, Signature Bank and Silvergate Capital Corp. were each swept into receivership. Although a statement by the Department of the Treasury, the Federal Reserve and the FDIC stated all depositors of SVB would have access to all of their money after only one business day of closure, including funds held in uninsured deposit accounts, borrowers under credit agreements, letters of credit and certain other financial instruments with SVB, Signature Bank or any other financial institution that is placed into receivership by the FDIC may be unable to access undrawn amounts thereunder. Although we are not a borrower or party to any such instruments with SVB, Signature or any other financial institution currently in receivership, if any of our lenders or counterparties to any such instruments, including PacWest or its affiliates, were to be placed into receivership, we may be unable to access such funds. In addition, counterparties to SVB credit agreements and arrangements, and third parties such as beneficiaries of letters of credit (among others), may experience direct impacts from the closure of SVB and uncertainty remains over liquidity concerns in the broader financial services industry. Similar impacts have occurred in the past, such as during the 2008- 2010 financial crisis. Inflation and rapid increases in interest rates have led to a decline in the trading value of previously issued government securities with interest rates below current market interest rates. Although the U. S. Department of Treasury, FDIC and Federal Reserve Board have announced a program to provide up to \$ 25 billion of loans to financial institutions secured by certain of such government securities held by financial institutions to mitigate the risk of potential losses on the sale of such instruments, widespread demands for customer withdrawals or other liquidity needs of financial institutions for immediate liquidity may exceed the capacity of such program. There is no guarantee that the U. S. Department of Treasury, FDIC and Federal Reserve Board will provide access to uninsured funds in the future in the event of the closure of other banks or financial institutions, or that they would do so in a timely fashion. Although we assess our banking relationships as we believe necessary or appropriate, our access to funding sources and other credit arrangements in amounts adequate to finance or capitalize our current and projected future business operations could be significantly impaired by factors that affect us, the financial institutions with which we have credit agreements or arrangements directly, or the financial services industry or economy in general. These factors could include, among others, events such as liquidity constraints or failures, the ability to perform obligations under various types of financial, credit or liquidity agreements or arrangements, disruptions or instability in the financial services industry or financial markets, or concerns or negative expectations about the prospects for companies in the financial services industry. These factors could involve financial institutions or financial services industry companies with which we have financial or business relationships, but could also include factors involving financial markets or the financial services industry generally. The results of events or concerns that involve one or more of these factors could include a variety of material and adverse impacts on our current and projected business operations and our financial condition and results of operations. These could include, but may not be limited to, the following: • delayed access to deposits or other financial assets or the uninsured loss of deposits or other financial assets; • loss of access to revolving existing credit facilities or**

other working capital sources and / or the inability to refund, roll over or extend the maturity of, or enter into new credit facilities or other working capital resources; • potential or actual breach of contractual obligations that require us to maintain letters or credit or other credit support arrangements; • potential or actual breach of financial covenants in our credit agreements or credit arrangements; • potential or actual cross- defaults in other credit agreements, credit arrangements or operating or financing agreements; or • termination of cash management arrangements and / or delays in accessing or actual loss of funds subject to cash management arrangements. In addition, investor concerns regarding the U. S. or international financial systems could result in less favorable commercial financing terms of, including higher interest rates on our- or loan agreement place restrictions costs and tighter financial and operating covenants, or systemic limitations on access to credit and liquidity sources, thereby making it more difficult for us to acquire financing on acceptable terms or at all. Any decline in available funding or access to our cash and liquidity resources could, among other risks, adversely impact our ability to meet our operating and expenses, financial flexibility. If we raise additional capital through debt obligations or fulfill our other obligations, result in breaches of our financing financial ; and / or contractual obligations or result in violations of federal or state wage and hour laws. Any of the these terms of impacts, or any new debt other impacts resulting from the factors described above or other related or similar factors not described above, could have material adverse impacts on our liquidity and our current and / or projected business operations and financial condition and results of operations. In addition, any further restrict deterioration in the macroeconomic economy our- or operating and financial flexibility services industry could lead to losses or defaults by our customers or suppliers, which in turn, could have a material adverse effect on our current and / or projected business operations and results of operations and financial condition. For example, a customer may fail to make payments when due, default under their agreements with us, become insolvent or declare bankruptcy, or a supplier may determine that it will no longer deal with us as a customer. In addition, a customer or supplier could be adversely affected by any of the liquidity or other risks that are described above as factors that could result in material adverse impacts on us, including but not limited to delayed access or loss of access to uninsured deposits or loss of the ability to draw on existing credit facilities involving a troubled or failed financial institution. Any customer or supplier bankruptcy or insolvency, or the failure of any customer to make payments when due, or any breach or default by a customer or supplier, or the loss of any significant supplier relationships, could result in material losses to us and may material adverse impacts on our business . On September 9, 2022, we entered into a Loan and Security Agreement with K2HV (the Loan Agreement (the Loan Agreement) with K2 HealthVentures LLC (K2HV) pursuant to which K2HV may provide us with convertible term loans in an aggregate principal amount of up to \$ 60 million, of which \$ 30 million was fully funded at the closing date in September 2022, \$ 10 million will be funded in the second tranche upon the achievement of certain financial and clinical milestones and \$ 20 million may be funded in the third tranche at K2HV' s discretion. Our obligations under the Loan Agreement are secured by a security interest in substantially all of our assets (other than intellectual property), subject to certain exceptions, and will be guaranteed by each of our the Company' s future direct or indirect subsidiaries, subject to certain exceptions. In addition, during the term of the Loan Agreement, we must maintain minimum unrestricted cash and cash equivalents equal to 5. 0 times the average cash burn measured over the trailing three- month period. The Loan Agreement contains customary representations and warranties, and also includes customary events of default, including payment default, breach of covenants, change of control, and material adverse effects. The Loan Agreement restricts certain activities, such as disposing of our the Company' s business or certain assets, incurring additional debt or liens or making payments on other debt, making certain investments and declaring dividends, acquiring or merging with another entity, engaging in transactions with affiliates or encumbering intellectual property, among others. Upon the occurrence of an event of default, a default interest rate of an additional 5 % per annum may be applied to the outstanding loan balances, and K2HV may declare all outstanding obligations immediately due and payable and exercise all of its rights and remedies as set forth in the Loan Agreement and under applicable law. Any declaration by K2HV of an event of default could significantly harm our business and prospects and could cause the price of our common stock to decline. We may not have enough available cash or be able to raise additional funds through equity or debt financings to repay these outstanding obligations at the time any event of default occurs. Further, if we raise any additional capital through debt financing, the terms of such additional debt could further restrict our operating and financial flexibility. Our future success depends on the successful development of our product candidates, which target hematologic malignancies and solid tumors utilizing T-cell receptor therapies, or TCR- T therapies. Advancing our product candidates creates significant challenges for us, including: • educating medical personnel about the administration of TCR- T therapies on a stand- alone basis or in combination with built- in immune and tumor modulators; • while no such side effects have been observed to date in any of our preclinical or clinical studies, educating medical personnel regarding the potential side effect profile of our product candidates, such as the potential adverse side effects related to cytokine release syndrome (CRS), GvHD, graft vs. host disease, neurotoxicity or autoimmune or rheumatologic disorders, which are the most common adverse side effects associated with engineered T cell therapies; • administering chemotherapy to patients in advance of administering our product candidates, which may increase the risk of adverse side effects; • sourcing clinical and, if licensed, commercial, supplies for the materials used to manufacture and process our product candidates; • manufacturing TCR- Ts efficiently and consistently without the use of viral vectors using our T- Integrate technology; • developing a complete shipment lifecycle and supply chain, including efficiently managing the shipment of patient cells from and to clinical sites, minimizing potential contamination to the cell product and effectively scaling manufacturing capacity to meet demand; • developing processes suitable for clinical manufacturing and obtaining related CMC regulatory approvals; • managing costs of inputs and other supplies while scaling production; • using medicines to manage adverse side effects of our product candidates, which may not adequately control the side effects and / or may have a detrimental impact on the potency of the treatment; • obtaining and maintaining regulatory approval from the FDA or comparable foreign regulatory authority for our product candidates; and • establishing sales and marketing capabilities upon obtaining any

regulatory approval to gain market acceptance of a novel therapy. In developing our product candidates, we have not exhaustively explored different options in the design of the TCR construct and in the method for manufacturing TCR- T therapies. We may find that our existing TCR- T therapy candidates and manufacturing process may be substantially improved with future design or process changes, necessitating development of new or additional TCR constructs and further clinical testing, which may delay the commercial launch of our first products. For example:

- We have made several TCR constructs and used preclinical studies to select product candidates to advance into clinical trials. The preclinical studies are limited in their ability to predict behavior in patients. As we gain experience working with TCR constructs, we may decide to select other TCR constructs for clinical development.
- The process by which patient cells are converted into a TCR- T product has many steps that can influence quality and activity. We have explored a subset of variables and expect to continue to improve and optimize the manufacturing process. Depending upon the nature of the process changes, we may be compelled to perform bridging studies and / or to re- start clinical development, causing delays in time to market and potentially introducing a risk of failure if new processes do not perform as expected. We are very early in our development efforts. **If we are unable to advance, we have cleared the IND applications for a number of** our product candidates through clinical development, obtain regulatory approval and ultimately commercialize our product candidates, or experience significant delays in doing so, our business will be materially harmed. We are very early in our development efforts. We have only recently cleared the INDs for TSC- 100 and TSC- 101, our most advanced product candidates as well as for T- Plex, TSC- 204- A0201 and TSC- 204- C0702. Our other product candidates are still in preclinical development. Our ability to generate product revenues, which we do not expect will occur for many years, if ever, will depend significantly on the successful development and eventual commercialization of one or more of our product candidates. The success of our product candidates will depend on several factors, including the following:

- successful development of a process suitable for clinical manufacturing;
- successful completion of preclinical studies;
- successful initiation of clinical trials;
- successful patient enrollment in and completion of clinical trials;
- receipt and related terms of marketing approvals and licensures from applicable regulatory authorities;
- obtaining and maintaining patent and trade secret protection and regulatory exclusivity for our product candidates;
- making arrangements with third- party manufacturers, or expanding our manufacturing capabilities, for both clinical and commercial supplies of our product candidates;
- establishing sales, marketing and distribution capabilities and launching commercial sales of our product candidates, if and when approved, whether alone or in collaboration with others;
- acceptance of our product candidates, if and when approved, by patients, the medical community and third- party payors;
- effectively competing with other cancer therapies;
- obtaining and maintaining third- party coverage and adequate reimbursement;
- maintaining a continued acceptable safety profile of our product candidates following licensure; and
- effectively competing with other therapies **including other cancer therapies**.

If we do not achieve one or more of these factors in a timely manner or at all, we could experience significant delays or be unable to successfully commercialize our product candidates, which would materially harm our business. Although many of our personnel have extensive experience in clinical development and manufacturing at other companies, we have limited experience as a company in conducting clinical trials and little direct experience managing a manufacturing facility for our product candidates. Although many of our personnel have extensive experience in clinical development and manufacturing at TScan other companies, we have limited experience as a company in conducting clinical trials at the Company. In part because of this lack of experience, we cannot be certain that our ongoing preclinical studies will be completed on time or if the planned preclinical and clinical trials studies and clinical trials will begin or be completed on time, if at all. Large- scale clinical trials would require significant additional financial and management resources and reliance on third- party clinical investigators, contract research organizations (CROs) and consultants. Relying on third- party clinical investigators, CROs and consultants may force us to encounter delays that are outside of our control. Although we have recently expanded our existing cell manufacturing facility for Phase 1 and Phase 2 clinical trials, we have limited direct experience as a company in expanding or managing a manufacturing facility. In part because of this lack of experience, we cannot be certain that any further expansion of our existing manufacturing facility will be completed on time, if at all, or if the planned clinical trials will begin or be completed on time, if at all. In part because of our inexperience, we may have unacceptable or inconsistent product quality success rates and yields, and we may be unable to maintain adequate quality control, quality assurance and qualified personnel. In addition, if we switch from manufacturing in our own facility to manufacturing in a different facility (for example, at an external **contract manufacturing organization, or CMO**) for one or more of our product candidates in the future or make changes to our manufacturing process, we may need to conduct additional preclinical studies to bridge our modified product candidates to earlier versions. Failure to successfully further expand our existing manufacturing facility could adversely affect our process and clinical development timelines, regulatory approvals, and the commercial viability of our product candidates. Our business is highly dependent on our current product candidates, and we must complete IND- enabling studies and clinical testing before we can seek regulatory approval and begin commercialization of any of our product candidates. There is no guarantee that any of our product candidates will proceed through preclinical or clinical development or achieve regulatory approval. The process for obtaining marketing approval for any product candidate is very long and risky and there will be significant challenges for us to address in order to obtain marketing approval as planned or, if at all. There is no guarantee that the results obtained in current **and planned** preclinical studies or **clinical trials** ~~our planned IND- enabling studies~~ of our current or future product candidates will be sufficient to obtain regulatory approval or marketing authorization for such product candidates. Negative results in the development of our lead product candidates may also impact our ability to obtain regulatory approval for our other product candidates, either at all or within anticipated timeframes because, although other product candidates may target different indications, the underlying proprietary platform, manufacturing process and development process is the same for all of our product candidates. Accordingly, a failure in any one of our programs may affect the ability to obtain regulatory approval to continue or conduct clinical programs for other product candidates. In addition, because we have limited financial and personnel resources and are placing significant focus on the development of our lead product candidates, we may forgo or delay pursuit of

opportunities with other future product candidates that later prove to have greater commercial potential. Our resource allocation decisions may cause us to fail to capitalize on viable commercial products or profitable market opportunities. Our spending on current and future research and development programs and other future product candidates for specific indications may not yield any commercially viable future product candidates. If we do not accurately evaluate the commercial potential or target market for a particular future product candidate, we may relinquish valuable rights to those future product candidates through collaborations, licensing or other royalty arrangements in cases in which it would have been more advantageous for us to retain sole development and commercialization rights to such future product candidates. ~~Our preclinical studies and clinical trials may fail to demonstrate adequately the safety, potency and purity of any of our product candidates, which would prevent or delay development, regulatory approval and commercialization.~~ Before obtaining regulatory approvals for the commercial sale of our product candidates, we must demonstrate through lengthy, complex and expensive preclinical studies and clinical trials that our product candidates are both safe and effective for use in each target indication. Preclinical and clinical testing is expensive and can take many years to complete, and its outcome is inherently uncertain. Failure can occur at any time during the preclinical study and clinical trial processes, and, because our product candidates are in an early stage of development, there is a high risk of failure, and we may never succeed in developing marketable products. The results of preclinical studies and early clinical trials of our product candidates may not be predictive of the results of later-stage clinical trials. There is typically an extremely high rate of attrition from the failure of product candidates proceeding through preclinical studies and clinical trials. Product candidates in later stages of clinical trials may fail to show the desired safety, potency and purity profile despite having progressed through preclinical studies and initial clinical trials. A number of companies in the biopharmaceutical industry have suffered significant setbacks in advanced clinical trials due to lack of potency or efficacy, insufficient durability of potency or efficacy or unacceptable safety issues, notwithstanding promising results in earlier trials. Most product candidates that commence preclinical studies and clinical trials are never approved as products. Any preclinical studies or clinical trials that we may conduct may not demonstrate the safety, potency and purity necessary to obtain regulatory approval to market our product candidates. If the results of our ongoing or future preclinical studies and clinical trials are inconclusive with respect to the safety, potency and purity of our product candidates, if we do not meet the clinical endpoints with statistical and clinically meaningful significance, or if there are safety concerns associated with our product candidates, we may be prevented or delayed in obtaining marketing approval for such product candidates. In some instances, there can be significant variability in safety, potency or purity results between different preclinical studies and clinical trials of the same product candidate due to numerous factors, including changes in trial procedures set forth in protocols, differences in the size and type of the patient populations, changes in and adherence to the clinical trial protocols and the rate of dropout among clinical trial participants. Clinical development involves a lengthy and expensive process with an uncertain outcome, and results of earlier studies and trials may not be predictive of future clinical trial results. If our preclinical studies and clinical trials are not sufficient to support regulatory approval of any of our product candidates, we may incur additional costs or experience delays in completing, or ultimately be unable to complete, the development of such product candidate. We cannot be certain that our ongoing and future preclinical study and clinical trial results will be sufficient to support regulatory approval of our product candidates. Clinical testing is expensive and can take many years to complete, and its outcome is inherently uncertain. Human clinical trials are expensive and difficult to design and implement, in part because they are subject to rigorous regulatory requirements. Failure or delay can occur at any time during the clinical trial process. We may experience delays in obtaining the FDA's authorization to initiate clinical trials under future ~~INDs~~ **IND applications**, completing ongoing preclinical studies of our other product candidates, and initiating our planned preclinical studies and clinical trials. Additionally, we cannot be certain that preclinical studies or clinical trials for our product candidates will begin on time, not require redesign, enroll an adequate number of subjects on time, or be completed on schedule, if at all. Clinical trials can be delayed or terminated for a variety of reasons, including delays or failures related to: • the FDA or comparable foreign regulatory authorities disagreeing as to the design or implementation of our clinical trials; • delays in obtaining regulatory approval to commence a clinical trial; • reaching agreement on acceptable terms with prospective CROs and clinical trial sites, the terms of which can be subject to extensive negotiation and may vary significantly among different CROs and clinical trial sites; • obtaining ~~institutional review board, or IRB~~ approval at each clinical trial site; • recruiting or retaining an adequate number of suitable patients to participate in a clinical trial, ~~including as a result of actions taken by governments and individuals in response to the COVID-19 pandemic~~; • having subjects complete a clinical trial or return for post-treatment follow-up; • clinical trial sites deviating from the approved clinical trial protocol or dropping out of a clinical trial; • addressing subject safety concerns that arise during the course of a clinical trial; • adding a sufficient number of clinical trial sites; or • obtaining sufficient product supply of product candidate for use in preclinical studies or clinical trials from third-party suppliers. We may experience numerous adverse or unforeseen events during, or as a result of, preclinical studies and clinical trials that could delay or prevent our ability to receive marketing approval or commercialize our product candidates, including: • we may receive feedback from regulatory authorities that requires us to modify the design of our clinical trials; • clinical trials of our product candidates may produce negative or inconclusive results, and we may decide, or regulators may require us, to conduct additional clinical trials or abandon our research efforts for our other product candidates; • the number of patients required for clinical trials of our product candidates may be larger than we anticipate, enrollment in these clinical trials may be slower than we anticipate or participants may drop out of our clinical trials at a higher rate than we anticipate; • our third-party contractors may fail to comply with regulatory requirements, fail to maintain adequate quality controls or be unable to provide us with sufficient product supply to conduct and complete preclinical studies or clinical trials of our product candidates in a timely manner, or at all; • we or our investigators might have to suspend or terminate clinical trials of our product candidates for various reasons, including non-compliance with regulatory requirements, a finding that our product candidates have undesirable side effects or other unexpected characteristics or a finding that the participants are being exposed to unacceptable health risks; • the cost of clinical trials of our product candidates may be greater than we anticipate; • ~~the any~~

lingering effects of **public health crises** the ongoing COVID-19 pandemic; • the quality of our product candidates or other materials necessary to conduct preclinical studies or clinical trials of our product candidates may be insufficient or inadequate; • regulators may revise the requirements for approving our product candidates, or such requirements may not be as we anticipate; and • our current or future collaborators may conduct clinical trials in ways they view as advantageous to them but that are suboptimal for us. If we are required to conduct additional clinical trials or other testing of our product candidates beyond those that we currently contemplate, if we are unable to successfully complete clinical trials of our product candidates or other testing, if the results of these trials or tests are not positive or are only moderately positive or if there are safety concerns, our business and results of operations may be adversely affected and we may incur significant additional costs. Accordingly, our clinical trial costs are likely to be significantly higher than those for more conventional therapeutic technologies or drug product candidates. We could also encounter delays if a clinical trial is suspended or terminated by us, by the IRBs of the institutions in which such clinical trials are being conducted, by the data safety monitoring board for such clinical trial or by the FDA or other regulatory authorities. Such authorities may suspend or terminate a clinical trial due to a number of factors, including failure to conduct the clinical trial in accordance with regulatory requirements or our clinical trial protocols, inspection of the clinical trial operations or trial site by the FDA or other regulatory authorities resulting in the imposition of a clinical hold, unforeseen safety issues or adverse side effects, failure to demonstrate a benefit from the product candidates, changes in governmental regulations or administrative actions or lack of adequate funding to continue the clinical trial. If we experience delays in the completion, or termination, of any preclinical study or clinical trial of our product candidates, the commercial prospects of our product candidates may be harmed, and our ability to generate revenues from any of these product candidates will be delayed or not realized at all. In addition, any delays in completing our preclinical studies or clinical trials may increase our costs, slow down our product candidate development and approval process and jeopardize our ability to commence product sales and generate revenues. Any of these occurrences may significantly harm our business, financial condition and prospects. In addition, many of the factors that cause, or lead to, a delay in the commencement or completion of clinical trials may also ultimately lead to the denial of regulatory approval of our product candidates. **Our business could be adversely affected by the effects of health epidemics, including the evolving effects of the COVID-19 pandemic, in regions where we, our partners or other third parties on which we rely have significant manufacturing facilities, concentrations of potential clinical trial sites or other business operations.** Public health crises such as pandemics or similar outbreaks could adversely impact our business. **Although the U. S. government has declared an end to the Public Health Emergency related to** In late 2019, a novel strain of a virus named SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), or coronavirus, which causes COVID-19, emerged in Wuhan, China and has reached most countries across the world, including all 50 states within the U. S., and including Waltham, Massachusetts, where **there may be lingering effects of the COVID-19** our primary office and laboratory space is located. The coronavirus pandemic **on our business** continues to evolve, with new variants of the SARS-CoV-2 virus identified, and has led to the implementation of various responses, including government-imposed quarantines, travel restrictions, mask and vaccine mandates and other public health safety measures. The extent to which COVID-19 **may further** impacts **impact** our operations or those of our third-party partners, including our preclinical studies or clinical trial operations, will depend on future developments, which are highly uncertain and cannot be predicted with confidence, including **the duration of the outbreak, new or more severe outbreaks,** information that will emerge concerning the variants of the coronavirus and the actions to contain the coronavirus or treat its impact, among others. **The continued spread of COVID-19 globally and the continued identification of new variants of the SARS-CoV-2 virus could adversely impact our preclinical or clinical trial operations in the U. S., including our ability to recruit and retain patients and principal investigators and site staff who, as healthcare providers, may have heightened exposure to COVID-19 if an outbreak occurs in their geography. For example, similar to other biopharmaceutical companies, we may experience delays in initiating IND-enabling studies, protocol deviations, enrolling our clinical trials, or dosing of patients in our clinical trials as well as in activating new trial sites. COVID-19 may also affect employees of third-party CROs located in affected geographies that we rely upon to carry out our clinical trials. In addition,** as a result of medical complications associated with microsatellite stable colorectal cancer (**or MSS CRC**), the patient populations that our most advanced and other product candidates target may be particularly susceptible to COVID-19, which may make it more difficult for us to identify patients able to enroll in our current and future clinical trials and may impact the ability of enrolled patients to complete any such trials. Any negative impact COVID-19 has to patient enrollment or treatment or the execution of our product candidates could cause costly delays to our clinical trial activities, which could adversely affect our ability to obtain regulatory approval for and to commercialize our product candidates, increase our operating expenses, and have a material adverse effect on our financial results. The adverse impact of public health crises such as pandemics or similar outbreaks in the countries and regions where we have concentrations of potential clinical trial sites or other business operations and where several of our third-party suppliers and contractors are located could adversely affect our business, including by causing significant disruption in the operations of third parties upon whom we rely. The COVID-19 pandemic **has presented and continues to present** a substantial public health and economic challenge around the world and **affected** is affecting employees, patients, communities and business operations, as well as the U. S. economy and financial markets. While the Company has implemented what it believes to be a reasonable protocol to ensure the safety and wellbeing of employees returning to the office, these measures may not be sufficient to mitigate the risks posed by the virus or otherwise be satisfactory to government authorities. The effects of our policies may negatively impact productivity, disrupt our business and delay our clinical programs and timelines, the magnitude of which will depend, in part, on the length and severity of any current or future restrictions and other limitations on our ability to conduct our business in the ordinary course. In connection with these measures, we may be subject to claims based upon, arising out of or related to COVID-19 and our actions and responses thereto, including any determinations that we may make to continue to operate or to re-open our facilities where permitted by applicable law. These and similar, and perhaps more severe, disruptions in our operations could negatively impact our business, financial

condition, results of operations and growth prospects. The COVID-19 pandemic might also affect our planned clinical trials. Site initiation and patient enrollment may be delayed due to prioritization of hospital resources toward the COVID-19 pandemic. Some patients may not be able to comply with clinical trial protocols if quarantines impede patient movement or interrupt healthcare services. Similarly, our ability to recruit and retain patients and principal investigators and site staff who, as **has** healthcare providers **largely resolved**, may have heightened exposure to COVID-19 and adversely impact our planned clinical trial operations. In addition, since the beginning of the COVID-19 pandemic, several vaccines for COVID-19 have received Emergency Use Authorization by the FDA and a number of those -- **the downstream** later received marketing approval. Additional vaccines may be authorized or approved in the future. The resultant demand for vaccines and potential for manufacturing facilities and materials to be commandeered under the Defense Production Act of 1950, or equivalent foreign legislation, may make it more difficult to obtain materials or manufacturing slots for the products needed for our clinical trials, which could lead to delays in these trials and / or issues with our commercial supply. The potential economic impact brought by, and the duration of, the COVID-19 pandemic may be difficult to assess or predict, the pandemic could result in significant and prolonged disruption of global financial markets, reducing our ability to access capital, which could in the future negatively affect **effects** our liquidity. In addition, a recession or market correction resulting from the spread of COVID-19 could materially affect our business and the value of our common stock. While the COVID-19 pandemic may continue to adversely affect our business operations, **and** the extent of the impact on our development and regulatory efforts and the future value of and market for our common stock will depend on future developments that are highly uncertain and cannot be predicted with confidence at this time, such as the ultimate duration of the pandemic, travel restrictions, quarantines, social distancing and business closure requirements in the U. S. and in other countries, and the effectiveness of actions taken globally to contain and treat COVID-19. In addition, to the extent the evolving effects of the COVID-19 pandemic adversely affects our business and results of operations, it may also have the effect of heightening many of the other risks and uncertainties described elsewhere in this "Risk Factors" section. We have established facilities to manufacture our clinical **scale** product candidates for our **ongoing** Phase 1 and **planned** Phase 2 clinical trials of our current product candidates. However, we rely on outside vendors to manufacture supplies for our manufacturing process, and we expect to rely on outside vendors to manufacture our product candidates for registration- enabling additional clinical trials as well as commercial sales. We have not yet caused any product candidates to be manufactured or processed on a commercial scale and may not be able to do so for any of our product candidates. We plan to **make changes as we work to** optimize the **existing** manufacturing process **to support product commercialization**. For example, **The process modifications** we may switch or be **intend to introduce will required-require** to switch from research- grade materials to commercial- grade materials in order to get regulatory approval of our product candidates, which could delay **receipt the commercialization of the products** regulatory approval, if any. We cannot be sure that **such even minor** changes in the process will result in therapies that are **safe efficacious** and **viable effective and licensed** for commercial sale. In addition, changes in the manufacturing process may result in the need to conduct additional bridging clinical trials to demonstrate product comparability. The facilities used by us or any third - party contract manufacturers to manufacture **and commercialize** our product candidates must be approved by the FDA or other foreign regulatory authorities following inspections that will be conducted after we submit **an application a BLA** to the FDA or other foreign regulatory authorities **to support commercialization**. If we engage third - party contract manufacturers, we may not control the manufacturing process of, and may be completely dependent on, such third - party contract manufacturing partners for compliance with cGMPs and any other regulatory requirements of the FDA or other regulatory authorities for the manufacture of our product candidates. We have limited control over the ability of any third - party contract manufacturers we engage to maintain adequate quality control, quality assurance and qualified personnel. Even with oversight, the third party may not be able to meet proper quality **standard standards** or its contractual obligations. If the FDA or a comparable foreign regulatory authority does not approve these facilities for the manufacture of our product candidates or if it withdraws any approval in the future, we may need to find alternative manufacturing facilities, which would significantly impact our ability to develop, obtain regulatory approval for or market our product candidates, if licensed. We, and any third - party contract manufacturers we engage for registration- enabling clinical trials, may experience manufacturing difficulties due to limited manufacturing experience, resource constraints or as a result of labor disputes, the **ongoing COVID-19 pandemic, the** U. S.- China trade war or unstable political environments. If we or any third - party contract manufacturers we engage were to encounter any of these difficulties, our ability to manufacture sufficient product supply for our preclinical studies and clinical trials, or to provide products for patients once approved, would be jeopardized. Many of the materials and reagents we expect to use in our processes are single or sole source, and / or have limited stability and as such supply disruptions could materially impact our ability to develop or manufacture products. For example, the type of cell culture media and cryopreservation buffer that we currently use in our manufacturing process for TSC- 100 and TSC- 101 are each only available from a limited number of suppliers. In addition, the cell processing equipment and tubing that we use in our current manufacturing process is currently sourced from a single supplier. Any interruption in the supply by those single source suppliers could impact our ability to continue development of any and all of our product candidates on the anticipated timelines or at all. We cannot guarantee that our product candidates will show any functionality in the solid tumor microenvironment. There are no approved TCR- T immunotherapies for solid tumors. While we plan to develop product candidates for use in solid tumors, including the TSC- 200 series, we cannot guarantee that our product candidates will show any functionality in the solid tumor microenvironment. The cellular environment in which solid tumor cells thrive is generally hostile to T cells due to factors such as the presence of immunosuppressive cells, humoral factors and limited access to nutrients. Our TCR- T- based product candidates may not be able to access the solid tumor, and even if they do, they may not be able to exert anti- tumor effects in a hostile solid tumor microenvironment. As a result, our product candidates may not demonstrate potency in solid tumors. If we are unable to make our product candidates function in solid tumors, our development plans and business may be significantly harmed. Since the

number of patients that we plan to dose in our initial clinical trials may be small, the results from such clinical trial, once completed, may be less reliable than results achieved in larger clinical trials, which may hinder our efforts to obtain regulatory approval for our product candidates. The preliminary results of clinical trials with smaller sample sizes can be disproportionately influenced by various biases associated with the conduct of small clinical trials, such as the potential failure of the smaller sample size to accurately depict the features of the broader patient population, which limits the ability to generalize the results across a broader community, thus making the clinical trial results less reliable than clinical trials with a larger number of patients. As a result, there may be less certainty that such product candidates would achieve a statistically significant effect in any future clinical trials. If we conduct any future clinical trials, we may not achieve a statistically significant result or the same level of statistical significance, if any, that we might have anticipated based on the results observed in our initial clinical trials. In addition, patients who are undergoing allogeneic HCT are very sick and may pass away from complications of their standard clinical transplantation and treatments thus making it difficult to ascertain the beneficial effects of the added T cell therapy. Further, toxicities of the T cell therapy ~~would~~ **may** be difficult to distinguish from the toxicity of the transplantation itself. Allogeneic HCT is a high- risk procedure that may result in complications or adverse events for patients in our clinical trials including those unrelated to the use of our products or for patients that use any of our product candidates, if approved. Stem cell transplantation can cure patients across multiple diseases, but its use carries with it risks of toxicity, serious adverse events and death. Because many of our therapies are used to prepare or treat patients undergoing allogeneic HCT, patients in our clinical trials or patients that use any of our product candidates may be subject to many of the risks that are currently inherent to this procedure. In particular, stem cell transplant involves certain known potential post- procedure complications that may manifest several weeks or months after a transplant and which may be more common in certain patient populations. For example, autoimmune cytopenia is a known and severe frequent complication of the transplant procedure in certain patients, that can result in death. If these or other serious adverse events, undesirable side effects, or unexpected characteristics are identified during the development of any of our product candidates, we may need to limit, delay or abandon our further clinical development of those product candidates, even if such events, effects or characteristics were the result of stem cell transplant or related procedures generally, and not directly or specifically caused or exacerbated by our product candidates. All serious adverse events or unexpected side effects are continually monitored per the clinical trial' s approved protocol. If serious adverse events are determined to be directly or specifically caused or exacerbated by our product candidates, we would follow the clinical trial protocol' s requirements, which call for our data safety monitoring committee to review all available clinical data in making a recommendation regarding the trial' s continuation. We may not be able to file ~~INDs~~ **IND applications** or IND amendments to commence additional clinical trials on the timelines we expect, and even if we are able to, the FDA may not permit us to proceed. We are currently advancing multiple TCRs for ~~six~~ solid tumor targets : ~~HPV16 E7 (TSC- 200), PRAME (TSC- 203), MAGE- A1 (TSC- 204), and the undisclosed targets of TSC- 201, TSC- 202 and TSC- 205. TSC- 204- C0702 is an~~ **and we** ~~HLA- C * 07: 02- restricted TCR for MAGE- A1 entering Phase 1 development; TSC- 204- A0201 is an HLA- A * 02: 01- restricted TCR for MAGE- A1 entering Phase 1 development; TSC- 200- A0201 is an HLA- A * 02: 01- restricted TCR for HPV16 E7 in IND- enabling activities; and TSC- 203- A0201 is an HLA- A * 02: 01- restricted TCR for PRAME in IND- enabling activities. TCRs for the TSC- 201 and TSC- 202 programs are in lead optimization and discovery, respectively. We expect to submit IND applications for additional TCRs in our solid tumor program~~ **throughout in 2023-2024**. However, we may not be able to file such ~~INDs~~ **IND applications** on the timelines we expect. For example, we may experience manufacturing delays or other delays with IND- enabling studies. Moreover, we cannot be sure that submission of an IND **application** will result in the FDA allowing clinical trials to begin, or that, once begun, issues will not arise that suspend or terminate clinical trials. Additionally, even if such regulatory authorities agree with the design and implementation of the clinical trials set forth in an IND **application**, we cannot guarantee that such regulatory authorities will not change their requirements in the future. These considerations also apply to new clinical trials we may submit as amendments to existing ~~INDs~~ **IND applications**. In addition, one of our key goals is to develop treatments consisting of a combination of TCR- ~~Ts~~ **T therapies**, which we refer to as multiplexed TCR- T therapy. Our plan is to assess the safety and preliminary efficacy of multiplexed TCR- T therapy early in the clinical development of our product candidates (e. g., Phase 1). While the FDA has cleared our T- Plex IND **application**, which allows us to combine our product candidates with each other in a multiplexed TCR- T therapy, we must still provide safety data for each individual product candidate or each variation or combination of a multiplexed TCR- T therapy. Any such requirements could result in material delays in the development timelines of our multiplexed TCR- T therapy candidates. Our product candidates may cause undesirable side effects or have other properties that could halt their clinical development, prevent their regulatory approval, require expansion of the trial size, limit their commercial potential, or result in significant negative consequences. Undesirable side effects caused by our product candidates could cause us or regulatory authorities, including IRBs, to interrupt, delay, or halt clinical trials and could result in a more restrictive label or the delay or denial of regulatory approval by the FDA or other comparable foreign regulatory authorities. Further, clinical trials by their nature utilize a sample of the potential patient population. With a limited number of subjects and limited duration of exposure, rare and severe side effects of our product candidates may only be uncovered with a significantly larger number of patients exposed to the drug. Because of the design of the dose escalation of our planned Phase 1 clinical trials, undesirable side effects could also result in an expansion in the size of our clinical trials, increasing the expected costs and timeline of our clinical trials. Additionally, results of our clinical trials could reveal a high and unacceptable severity and prevalence of side effects or unexpected characteristics, which may stem from our therapies specifically or may be due to an illness from which the clinical trial subject is suffering. For example, there could be an increased risk of ~~graft-versus-host disease (GvHD)~~ with our TCR- ~~Ts~~ **T therapy** in the post- HCT setting. GvHD is a common toxicity in patients undergoing allogeneic HCT, the focus of our hematologic malignancies program. GvHD occurs because donor T cells, which are part of the standard stem cell product, misrecognize antigens in the patient as foreign and attack tissues and organs that express those antigens. GvHD may be worsened by our TCR- T **therapy**

candidates because they are derived from donor T cells. While the engineered T cells express a new **TCR T-cell receptor** that is specific for the intended target antigen and is not expected to cause GvHD, those T cells may have low levels of endogenous **TCR T-cell receptors** that have the potential to misrecognize patient antigens as foreign and worsen GvHD. In solid tumor patients, autoimmunity may occur after TCR- T treatment. TCR- T therapies are generated from a patient's own T cells isolated from their peripheral blood. There is a risk that this process will expand a patient's own T cell that has autoreactivity, or that may recognize healthy cells, and upon re- infusion may trigger an autoimmune reaction resulting in damage to normal tissues and potentially even death. Autoimmune reaction triggered by an interaction between a patient's naturally occurring antibodies and engineered T cells is a theoretical safety risk of product candidates we develop using our proprietary platform. If a patient's self- generated antibodies were directed to a target expressed on the surface of cells in normal tissue (autoantibodies), engineered T cells would be directed to attack these same tissues, potentially resulting in off- tumor effects. These autoantibodies may be present whether or not the patient has an active autoimmune **disease-disorder**. In our clinical testing, we plan to take steps to minimize the likelihood that this occurs, for example by excluding patients with a history of **a severe autoimmune disease-disorder** from our trials. There is no guarantee, however, that we will not observe autoimmune reactions in the future and no guarantee that if we do, that we will be able to implement interventions to address the risk. In addition, immunogenicity, which is the reaction between a patient's immune system and a foreign protein outside of the autoimmune context, is an additional theoretical safety risk of product candidates we develop using our proprietary platform. Patients' immune systems may recognize the TCR construct on the TCR- T product as a foreign protein and fight against it, potentially rendering it ineffective, or even provoking an allergic / anaphylactoid response or other adverse side effects. The immunogenic potential of novel therapeutics like TCR- T therapies is difficult to predict. There is no guarantee that we will not observe immunogenic reactions in the future and no guarantee that if we do, that we will be able to implement interventions to address the risk. If unacceptable toxicities arise in the development of our product candidates, we could suspend or terminate our clinical trials or the FDA or comparable foreign regulatory authorities, or local regulatory authorities such as IRBs, could order us to cease clinical trials. Competent national health authorities, such as the FDA, could also deny approval of our product candidates for any or all targeted indications. Treatment- related side effects could also affect patient recruitment or the ability of enrolled patients to complete the clinical trial or result in potential product liability claims. In addition, these side effects may not be appropriately recognized or managed by the treating medical staff, as toxicities resulting from T cell therapy are not normally encountered in the general patient population and by medical personnel. We expect to have to train medical personnel using our product candidates to understand the side effect profile of our product candidates for both our planned clinical trials and upon any commercialization of any product candidates, if licensed. Inadequate training in recognizing or managing the potential side effects of our product candidates could result in patient deaths. Any of these occurrences may significantly harm our reputation as well as business, financial condition and prospects. Certain patients may lack sufficient T cells for our autologous product candidates to be effective. For autologous TCR- T therapy, our TCR- T **therapy** candidates are manufactured by using a vector to insert genetic information encoding the TCR construct into the patient's own T cells. This manufacturing process is dependent on **a** collecting a sufficient number of T cells from the patient. We may not be able to effectively treat some patients if they have an insufficient number of T cells to enable our manufacturing process, which could adversely impact our ability to progress the clinical development of such product candidates and could also adversely impact the commercial viability of such product candidates. Our product candidates may target healthy cells expressing target antigens leading to potentially fatal adverse effects. Our product candidates target specific antigens that are also potentially expressed on healthy cells. Our product candidates may target healthy cells, leading to serious and potentially fatal adverse effects. In our planned clinical trials of our product candidates, we plan to use a dose escalation model to closely monitor the effect of our product candidates on vital organs and other potential side effects. Even though we intend to closely monitor the side effects of our product candidates in both preclinical studies and clinical trials, we cannot guarantee that products will not target and kill healthy cells. Our product candidates may have serious and potentially fatal cross- reactivity to other peptides or protein sequences within the body. Our product candidates may recognize and bind to a peptide unrelated to the target antigen to which it is designed to bind. If this peptide is expressed within normal tissues, our product candidates may target and kill the normal tissue in a patient, leading to serious and potentially fatal adverse effects. Detection of any cross- reactivity may halt or delay any ongoing clinical trials for any of our TCR- T **therapy candidate candidates** and prevent or delay regulatory approval. Unknown cross- reactivity of the TCR- T binding domain to related proteins could also occur. We have also developed a preclinical screening process to identify cross- reactivity of T cell binders. Any cross- reactivity that impacts patient safety could materially impact our ability to advance our product candidates into clinical trials or to proceed to marketing approval and commercialization. The vectors used to manufacture our TCR- **Ts T therapies** may incorrectly modify the genetic material of a patient's T cells, potentially triggering the development of a new cancer or other adverse events. Our TCR- T **therapy** candidates are manufactured by using a vector to insert genetic information encoding the TCR construct into the patient's T cells. The TCR construct is then integrated into the natural TCR complex and transported to the surface of the patient's T cells. Because the vector modifies the genetic information of the T cell, there is a risk that modification will occur in the wrong place in the T cell's genetic code, leading to vector- related insertional oncogenesis, and causing the T cell to become cancerous. If the cancerous T cell is then administered to the patient with the TCR- T **therapy** candidates, the cancerous T cell could trigger the development of a new cancer in the patient. We use non- viral transposon / transposase to insert genetic information into T cells. The risk of insertional oncogenesis remains a concern for gene therapy and we cannot **assure-guarantee** that it will not occur in any of our ongoing or planned preclinical studies or clinical trials. There is also the potential risk of delayed adverse events following exposure to gene therapy products due to persistent biological activity of the genetic material or other components of vectors used to carry the genetic material. The FDA has stated that vectors possess characteristics that may pose high risks of delayed adverse events. Non- viral transposon / transposase systems have limited clinical history, **and such** their safety profile is still to be determined. If any such

adverse events occur, further advancement of our preclinical studies or clinical trials could be halted or delayed, which would have a material adverse effect on our business and operations. We may experience difficulties in patient enrollment in our clinical trials for a variety of reasons. The timely completion of clinical trials in accordance with their approved protocols depends on, among other things, our ability to enroll a sufficient number of patients who remain in the clinical trial until its conclusion. The enrollment of patients depends on many factors, including:

- the patient eligibility criteria defined in the clinical trial protocol, particularly those who meet the requisite genetic criteria. For example, for our hematologic malignancies program, patients would have to be HLA- A * 02: 01 positive and positive for the minor antigen HA- 1 or HA- 2 to be eligible for treatment with TSC- 100 or TSC- 101, respectively;
- for our hematologic malignancies program, the ability to find a donor who **must** ~~has to~~ be mismatched with the patient either for the HLA type or the minor antigen type to ensure that the engineered T cell therapy does not recognize donor- derived blood cells;
- ~~the~~ **any continuing or lingering** impact of **public health crises** ~~the COVID-19 pandemic~~ on clinical trial initiation and enrollment;
- the size of the patient population required for analysis of the clinical trial's primary endpoints;
- the proximity of patients to clinical trial sites;
- the design of the clinical trial;
- our ability to recruit clinical trial investigators with the appropriate competencies and experience;
- our ability to obtain and maintain patient consents;
- reporting of the preliminary results of any of our clinical trials;
- risk that patients enrolled in clinical trials will drop out of the clinical **trial** or pass away from disease- related complications or complications from their standard clinical therapy before they can experience benefits of the engineered T cell therapy; and
- for patients in our solid tumor program, the ~~patients~~ **patient' s** need for sufficient T cells in order for the engineered T cell product to be manufactured from their autologous T cells.

In addition, our clinical trials will compete with other clinical trials for product candidates that are in the same therapeutic areas as our product candidates, and this competition will reduce the number and types of patients available to us because some patients who might have opted to enroll in our clinical trials may instead opt to enroll in a clinical trial being conducted by one of our competitors. Since the number of qualified clinical investigators is limited, we expect to conduct some of our clinical trials at the same clinical trial sites that some of our competitors use, which will reduce the number of patients who are available for our clinical trials at such clinical trial sites. Moreover, because our product candidates represent a departure from more commonly used methods for cancer treatment, potential patients and their doctors may be inclined to use conventional therapies, such as chemotherapy and HCT, rather than enroll patients in any future clinical trial. Additionally, because some of our clinical trials are expected to be in patients with relapsed / refractory cancer, the patients are typically in the late stages of their disease and may experience disease progression independent from our product candidates, making them unevaluable for purposes of the clinical trial and requiring additional patient enrollment. Delays in completing patient enrollment may result in increased costs or may affect the timing or outcome of our ongoing and planned clinical trials, which could prevent completion or commencement of these clinical trials and adversely affect our ability to advance the development of our product candidates. Research and development of biopharmaceutical products is inherently risky. We may not be successful in our efforts to use and enhance our TScan technology discovery platform and TCR technologies to create a pipeline of product candidates and develop commercially successful products, or we may expend our limited resources on programs that do not yield a successful product candidate and fail to capitalize on product candidates or diseases that may be more profitable or for which there is a greater likelihood of success. If we fail to develop additional product candidates, our commercial opportunity will be limited. A key element of our strategy is to use our TScan technology discovery platform to discover the targets of T cells in oncology, autoimmune **disorder** and infectious disease applications to build a pipeline of novel product candidates. We and our collaborators are simultaneously pursuing clinical development of multiple product candidates developed employing our TCR technologies. We are at an early stage of development and our TScan technology discovery platform has not yet led, and may never lead, to approved or commercially successful products. All of our current product candidates are being developed by leveraging the same or similar underlying proprietary platform, manufacturing process and development program. As a result, an issue with one product candidate or failure of any one program to obtain regulatory approval could lead to a failure of our entire pipeline of product candidates. Even if we are successful in continuing to build our pipeline, obtaining regulatory approvals and commercializing additional product candidates may require substantial additional funding and are prone to the risks of failure inherent in **medical-biopharmaceutical** product development. Investment in biopharmaceutical product development involves significant risk that any potential product candidate will fail to demonstrate adequate efficacy or an acceptable safety profile, gain regulatory approval, and become commercially viable. We cannot provide any assurance that we will be able to successfully advance any of these additional product candidates through the development process. Our research programs may initially show promise in identifying potential product candidates, yet fail to yield product candidates for clinical development or commercialization for many reasons, including the following:

- our research methodology, including our screening technology, may not successfully identify additional product candidates;
- our pursuit of difficult- to- drug targets may make it challenging to design potential product candidates;
- results of clinical trials conducted by others on similar indications or on compounds with similar mechanisms of action could result in our having to conduct additional or cost prohibitive clinical trials, which could delay development and possibly make commercialization prohibitively expensive;
- we may encounter product manufacturing difficulties that limit yield, produce undesirable characteristics, that increase the cost of goods, cause delays, or make the product candidates unmarketable;
- our product candidates may cause adverse effects in patients or subjects, even after successful initial toxicology studies, which may make the product candidates unmarketable;
- our product candidates may not demonstrate a meaningful benefit to patients or subjects; and
- our collaboration partners may change their development profiles or plans for potential product candidates or abandon a therapeutic area or the development of a partnered product. If any of these events occur, we may be forced to abandon our development efforts for a program or programs, which would have a material adverse effect on our business, operating results and prospects and could potentially cause us to cease operations. Research programs to identify new product candidates require substantial technical, financial and human resources. We may focus our efforts and resources on potential programs or product candidates that

ultimately prove to be unsuccessful. If we are unable to identify suitable compounds for preclinical and clinical development, we will not be able to obtain revenues from the sale of drugs in future periods, which likely would result in significant harm to our business prospects and financial position. ~~The market opportunities for our product candidates may be relatively small as they will be limited to those patients who are ineligible for or have failed prior treatments and our estimates of the prevalence of our target patient populations may be inaccurate.~~ Cancer therapies are sometimes characterized as first line, second line, or third line, and the FDA often approves new therapies initially only for a particular line of use. When cancer is detected early enough, first line therapy is sometimes adequate to cure the cancer or prolong life without a cure. Whenever first line therapy, usually chemotherapy, antibody drugs, tumor- targeted small molecules, hormone therapy, radiation therapy, surgery, or a combination of these, proves unsuccessful, second line therapy may be administered. Second line therapies often consist of more chemotherapy, radiation, antibody drugs, tumor- targeted small molecules, or a combination of these. Third line therapies can include HCT in certain cancers, chemotherapy, antibody drugs and small molecule tumor- targeted therapies, more invasive forms of surgery and new technologies. We expect to initially seek approval of our product candidates in most instances at least as a second or third line therapy, for use in patients to prevent relapse in patients undergoing HCT. Subsequently, for those product candidates that prove to be sufficiently safe and beneficial, if any, we would expect to seek approval as a second line therapy and potentially as a first line therapy, but there is no guarantee that our product candidates, even if licensed as a second or third or subsequent line of therapy, would be licensed for an earlier line of therapy, and, prior to any such approvals, we may have to conduct additional clinical trials. Consequently, the potentially addressable patient population for our product candidates may be extremely limited or may not be amenable to treatment with our product candidates. Our projections of both the number of people who have the cancers we are targeting, as well as the subset of people with these cancers in a position to receive a particular line of therapy and who have the potential to benefit from treatment with our product candidates, are based on our beliefs and estimates. These estimates have been derived from a variety of sources, including scientific literature, surveys of clinics, patient foundations or market research, and may prove to be incorrect. Further, new therapies may change the estimated incidence or prevalence of the cancers that we are targeting. Consequently, even if our product candidates are approved for a second or third line of therapy, the number of patients that may be eligible for treatment with our product candidates may turn out to be much lower than expected. Our product candidates rely on the use of protein binding domains, or binders, to target specific cancers, which we may develop or which may be developed by third parties. We are limited in our ability to apply our product candidates to a wider range of potential target cancers by our ability to develop, partner for or acquire these binders on commercially reasonable terms. TCR- T therapies require the use of antigen- specific protein binding domains ~~(, or binders,)~~ which guide the TCR- Ts and bind to the antigens on the surface of a tumor to target specific types of cancers. Our ability to develop and commercialize our product candidates will depend on our ability to develop these binders or partner for such binders on commercially reasonable terms for use in clinical trials as well as the availability of such binders for use in commercialized products, if licensed. We cannot ensure that we will have a steady supply of binders that we can utilize in combination with the TCR construct to develop future product candidates. If we are unable to enter into such collaborations on commercially reasonable terms or fail to realize the benefits of any such collaboration, we may be limited to using antibody fragments that we are able to independently develop which may limit the ability of our product candidates to target and kill cancer cells. The failure to enter into a successful collaboration or to develop our own binders may delay our development timelines, increase our costs and jeopardize our ability to develop future product candidates as a commercially viable drug, which could result in delays in product development and harm our business. We currently have no marketing and sales organization and have no experience as a company in marketing products. If we are unable to establish marketing and sales capabilities or to enter into agreements with third parties to market and sell our product candidates, if licensed, we may not be able to generate product revenue. We currently have no sales, marketing or distribution capabilities and have no experience as a company in marketing products. We intend to develop an in- house marketing organization and sales force, which will require significant capital expenditures, management resources and time. We will have to compete with other pharmaceutical and biotechnology companies to recruit, hire, train and retain marketing and sales personnel. If we are unable or decide not to establish internal sales, marketing and distribution capabilities, we will pursue collaborative arrangements regarding the sales and marketing of our product candidates, if licensed. However, there can be no assurance that we will be able to establish or maintain such collaborative arrangements, or if we are able to do so, that they will have effective sales forces. Any revenue we receive will depend upon the efforts of such third parties, which may not be successful. We may have little or no control over the marketing and sales efforts of such third parties and our revenue from product sales may be lower than if we had commercialized our product candidates ourselves. We may also face competition in our search for third parties to assist us with the sales and marketing efforts of our product candidates. There can be no assurance that we will be able to develop in- house sales and distribution capabilities or establish or maintain relationships with third party collaborators to commercialize any product in the ~~United States~~ **U. S.** or overseas. Even if we obtain regulatory approval of our product candidates, the products may not gain market acceptance among physicians, patients, hospitals, cancer treatment centers and others in the medical community. The use of engineered T cells as a potential cancer treatment is a recent development and may not become broadly accepted by physicians, patients, hospitals, cancer treatment centers and others in the medical community. Various factors will influence whether our product candidates are accepted in the market, including: • the clinical indications for which our product candidates are licensed; • physicians, hospitals, cancer treatment centers and patients considering our product candidates as a safe and effective treatment; • the potential and perceived advantages of our product candidates over alternative treatments; • our ability to demonstrate the advantages of our product candidates over other TCR- T therapies; • the prevalence and severity of any side effects; • the prevalence and severity of any side effects for other adoptive cell therapies, TCR- T therapies and public perception of other adoptive cell therapies ~~and~~ TCR- T therapies; • product labeling or product insert requirements of the FDA or other regulatory authorities; • limitations or warnings contained in the labeling approved by the FDA; • the timing of market

introduction of our product candidates as well as competitive products; • the cost of treatment in relation to alternative treatments; • the availability of adequate coverage, reimbursement and pricing by third-party payors and government authorities; • willingness of patients to pay out-of-pocket in the absence of coverage by third-party payors and government authorities; • relative convenience and ease of administration, including as compared to alternative treatments and competitive therapies; and • the effectiveness of our sales and marketing efforts. In addition, although we are not utilizing embryonic stem cells or replication competent vectors, adverse publicity due to the ethical and social controversies surrounding the therapeutic use of such technologies, and reported side effects from any clinical trials using these technologies or the failure of such clinical trials to demonstrate that these therapies are safe and effective may limit market acceptance of our product candidates. If our product candidates are licensed but fail to achieve market acceptance among physicians, patients, hospitals, cancer treatment centers or others in the medical community, we will not be able to generate significant revenue. In addition, although our product candidates differ in certain ways from other TCR- T therapy approaches, serious adverse events or deaths in other clinical trials involving engineered TCR, or other T cell products or with our use of licensed TCR- T therapy candidates, even if not ultimately attributable to our product candidates, could **negatively impact our business. For example, in November 2023, the FDA announced that it would conduct an investigation into reports of T- cell malignancies following BCMA- directed or CD19- directed autologous CAR- T cell immunotherapies following reports of T cell lymphoma in patients receiving these therapies. In January 2024, the FDA determined that new safety information related to T cell malignancies should be included in the boxed warning in the labeling for BCMA- and CD- 19- directed genetically modified autologous T cell immunotherapies. While our TCR- T therapy candidates utilize a different mechanism of action, the FDA’ s investigation into CAR- T therapies and other similar actions could** result in increased government regulation, unfavorable public perception and publicity, potential **impacts on enrollment in our clinical trials, potential** regulatory delays in the testing, **approval** or licensing of our product candidates, stricter labeling requirements, **for- or those product candidates that are licensed, and a decrease decreased** in demand for **our any such** product candidates. Even if our product candidates achieve market acceptance, we may not be able to maintain that market acceptance over time if new products or technologies are introduced that are more favorably received than our product candidates, are more cost effective or render our product candidates obsolete. A variety of risks associated with marketing our product candidates internationally could materially adversely affect our business. We plan to seek regulatory approval of our product candidates outside of the **United States U. S.** and, accordingly, we expect that we will be subject to additional risks related to operating in foreign countries if we obtain the necessary approvals, including: • differing regulatory requirements in foreign countries; • unexpected changes in tariffs, trade barriers, price and exchange controls and other regulatory requirements; • economic weakness, including inflation, or political instability in particular foreign economies and markets; • compliance with tax, employment, immigration and labor laws for employees living or traveling abroad; • foreign taxes, including withholding of payroll taxes; • foreign currency fluctuations, which could result in increased operating expenses and reduced revenue, and other obligations incident to doing business in another country; • difficulties staffing and managing foreign operations; • workforce uncertainty in countries where labor unrest is more common than in the **United States U. S.**; • potential liability under the Foreign Corrupt Practices Act of 1977 or comparable foreign regulations; • challenges enforcing our contractual and intellectual property rights, especially in those foreign countries that do not respect and protect intellectual property rights to the same extent as the **United States U. S.**; • production shortages resulting from any events affecting raw material supply or manufacturing capabilities abroad; and • business interruptions resulting from geo- political actions, including war and terrorism. These and other risks associated with international operations may materially adversely affect our ability to attain or maintain profitable operations. The biopharmaceutical industry is characterized by intense competition and rapid innovation. Our competitors may be able to develop other products or drugs that are able to achieve similar or better results. Our potential competitors include larger biotechnology and pharmaceutical companies with greater resources than us, academic institutions, governmental agencies, public and private research institutions and early stage or smaller companies. Many of our competitors have substantially greater financial, technical and other resources, such as larger research and development staff, experienced marketing and manufacturing organizations and well- established sales forces. Further, our competitors may have more financial resources, greater access to capital and diversified product offerings and revenue sources, which may give our competitors an advantage over us **in weathering the effects of the ongoing COVID- 19 pandemic**. In addition, many of these competitors are active in seeking patent protection and licensing arrangements in anticipation of collecting royalties for use of technology that they have developed. Mergers and acquisitions in the biotechnology and pharmaceutical industries may result in even more resources being concentrated in our competitors. Competition may increase further as a result of advances in the commercial applicability of technologies and greater availability of capital for investment in these industries. Our competitors, either alone or with collaborative partners, may succeed in developing, acquiring or licensing on an exclusive basis drug or biologic products that are more effective, safer, more easily commercialized or less costly than our product candidates or may develop proprietary technologies or secure patent protection that we may need for the development of our technologies and products. We believe the key competitive factors that will affect the development and commercial success of our product candidates are safety, potency, purity, tolerability, reliability, convenience of use, price and reimbursement. Specifically, by genetically engineering T –cell therapies, we face significant competition in the TCR space from many companies. For additional information regarding our competition, see “ Item 1. Business – Competition ” in this Annual Report. Even if we obtain regulatory approval of our product candidates, the availability and price of our competitors’ products could limit the demand and the price we are able to charge for our product candidates. We may not be able to implement our business plan if the acceptance of our product candidates is inhibited by price competition or the reluctance of physicians to switch from existing methods of treatment to our product candidates, or if physicians switch to other new drug or biologic products or choose to reserve our product candidates for use in limited circumstances. Moreover, the development and manufacturing costs associated with engineered T –cell therapies may

make it difficult to compete with alternative products that may be simpler and cheaper to develop and manufacture. Our internal computer systems, or those used by our third-party CROs or other contractors or consultants, may fail or suffer security breaches or other unauthorized or improper access, which could result in a material disruption of the development programs of our product candidates. Despite the implementation of security measures, our internal computer systems and those of our current and future CROs and other contractors and consultants are vulnerable to a variety of disruptions and data privacy and information security incidents, including data breaches, attacks by hackers and other malicious third parties (including the deployment of computer viruses, malware, ransomware, denial-of-service attacks, social engineering, and other events that affect service reliability and threaten the confidentiality, integrity, and availability of information), unauthorized access, natural disasters, fires, terrorism, war, telecommunications or electrical interruptions or failures, employee error or malfeasance or other malicious or inadvertent disruptions. For example, the ongoing conflict between Russia and Ukraine has led to an increase in cyberattacks on the Ukraine, including its government, companies, institutions and people, as well as the financial and communications infrastructure of other countries, companies and individuals therein. Additionally, the increased usage of computers operated on home networks ~~due to shelter-in-place, stay-at-home advisories or similar restrictions related to the COVID-19 pandemic~~ may make our or our partners' systems more susceptible to security breaches. While we have not experienced any such material system failure or security breach to date, if such an event were to occur and cause interruptions in our operations, it could result in a material disruption of our development programs and our business operations. For example, the loss of data from completed or future preclinical studies and clinical trials could result in delays in our regulatory approval efforts and significantly increase our costs to recover or reproduce the data. Likewise, to the extent we rely on third parties for the manufacture of our product candidates and to conduct clinical trials, similar events relating to their computer systems could also have a material adverse effect on our business, financial condition, results of operations and prospects. Unauthorized disclosure of sensitive or confidential data, including personally identifiable information, whether through a breach of computer systems, systems failure, employee negligence, fraud or misappropriation, or otherwise, or unauthorized access to or through our information systems and networks, whether by our employees or third parties, could result in negative publicity, legal liability and damage to our reputation. Unauthorized disclosure of personally identifiable information could also expose us to sanctions for violations of data privacy laws and regulations around the world. As we become more dependent on information technologies to conduct our operations, cyber incidents, including deliberate attacks and attempts to gain unauthorized access to computer systems and networks, may increase in frequency and sophistication. These threats pose a risk to the security of our systems and networks and to the confidentiality, availability and integrity of our data, and these risks apply both to us and to third parties on whose systems we rely for the conduct of our business. Because the techniques used to obtain unauthorized access, disable or degrade service or sabotage systems change frequently and often are not recognized until launched against a target, we and our partners or collaborators may be unable to anticipate these techniques or to implement adequate preventative measures. Further, we do not have any control over the operations of the facilities or technology of our cloud and service providers, including any third-party vendors that collect, process and store personal data on our behalf. Our systems, servers and platforms and those of our service providers may be vulnerable to computer viruses or physical or electronic break-ins that our or their security measures may not detect. Individuals able to circumvent such security measures may misappropriate our confidential or proprietary information, disrupt our operations, damage our computers or otherwise impair our reputation and business. We may need to expend significant resources and make significant capital investments to protect against security breaches or to mitigate the impact of any such breaches. There can be no assurance that we or our third-party providers will be successful in preventing cyber-attacks or successfully mitigating their effects. To the extent that any disruption or security breach were to result in a loss of, or damage to, our data or applications, or inappropriate disclosure of confidential or proprietary information, we could incur liability and the further development and commercialization of our product candidates could be delayed. Security incidents, loss of data or modification of information, and other disruptions could compromise information related to our business or prevent us from accessing critical information, result in a significant disruption of our activities and expose us to liability, which could adversely affect our business and our reputation. In the ordinary course of our business, we collect and store information, including personal information, intellectual property and proprietary business information that we own or control or have an obligation to protect. For example, we collect and store research and development information, employee data, commercial information, customer information and business and financial information. We and our service providers, including security and infrastructure vendors, manage and maintain our data using a combination of on-site systems and cloud-based data centers. We face a number of risks related to protecting critical information, including inappropriate use or disclosure, unauthorized access or acquisition, or inappropriate modification of, critical information. We also face the risk of being unable to access our critical information or technology systems due to actual or threats of ransomware, unauthorized encryption, or other malicious activity. We face the risk of being unable to adequately monitor, audit and modify our controls over our critical information. These risks extend to third-party service providers and subcontractors we use to assist us in managing our information or otherwise process it on our behalf. The secure processing, storage, maintenance and transmission of our critical information is vital to our operations and business strategy, and we devote significant resources to protecting such information. Although we take reasonable measures to protect critical information and other data from unauthorized access, acquisition, use or disclosure, our information technology and infrastructure and that of our service providers handling and storing information on our behalf may be vulnerable to a variety of disruptions, including data breaches, attacks by hackers and other malicious third parties (including the deployment of computer viruses, malware, ransomware, denial-of-service attacks, social engineering, and other events that affect service reliability and threaten the confidentiality, integrity, and availability of information), unauthorized access, natural disasters, fires, terrorism, war, telecommunications or electrical interruptions or failures, employee error or malfeasance or other malicious or inadvertent disruptions. In particular, the risk of a security breach or disruption, particularly through cyber-attacks or cyber intrusion, has generally increased as the number, intensity, and

sophistication of attempted attacks and intrusions from around the world have increased. We may not be able to anticipate all types of security threats, and we may not be able to implement preventive measures that are effective against all such security threats. Because the techniques used by cyber criminals change frequently, may not be recognized until launched, and can originate from a wide variety of sources, including outside groups such as external service providers, organized crime affiliates or terrorist organizations, we and our ~~services-~~ **service** providers and other partners may be unable to anticipate these techniques or implement adequate preventative measures. Further, we do not have any control over the operations of the facilities or technology of third parties that collect, process and store sensitive information on our behalf. Any unauthorized access or acquisition, breach, or other loss, of information could result in legal claims or proceedings, and liability under federal, state or foreign laws regarding the privacy and protection of information, including personal information, and could disrupt our operations and harm our reputation. In addition, notice of breaches may be required to affected individuals, regulators, credit reporting agencies or the media. Any such publication or notice could harm our reputation and our ability to compete. The financial exposure from the events referenced above could either not be insured against or not be fully covered through any insurance that we may maintain, and there can be no assurance that the limitations of liability in any of our contracts would be enforceable or adequate or would otherwise protect us from liabilities or damages as a result of the events referenced above. Any of the foregoing could have a material adverse effect on our business, financial condition, results of operations and prospects. Manufacturing and administering our product candidates is complex and we may encounter difficulties in production, particularly with respect to process development or scaling up of our manufacturing capabilities. If we encounter such difficulties, our ability to provide supply of our TCR- ~~T~~ **therapy** candidates for clinical trials or for commercial purposes could be delayed or stopped. The process of manufacturing and administering our product candidates is complex and highly regulated. The manufacture of our product candidates involves complex processes, including the manufacture of a transposon containing the genetic information for our TCR construct, a transposase used to insert the transposon genetic information into the T cell genome, and manufacturing operations to ensure the safety, integrity, strength, **sterility**, purity, and quality of the final product. More specifically, the manufacture of our product candidates includes harvesting white blood cells from the patient, isolating certain T cells from the white blood cells, combining patient T cells with our delivery vector through a process known as ~~transduction-~~ **transfection**, selection of modified T cells from the population, expanding the selected ~~transduced-~~ **transfected** T cells to obtain the desired dose, aseptically filling product into vessels suitable for storage, distribution, and clinical dosing, and ultimately infusing the ~~modified-~~ **engineered** T cells back into the patient's body. As a result of the complexities entailed in this process, our manufacturing and supply costs will be higher than those ~~at-~~ **of** more traditional manufacturing processes and the manufacturing process is less reliable and more difficult to reproduce. Additionally, the number of facilities that are capable of harvesting patients' cells for the manufacture of our product candidates and other autologous cell therapy products and product candidates is limited. As the number of autologous cell therapy products and product candidates increases, the limited number of facilities capable of harvesting patients' cells could result in delays in the manufacture and administration of our product candidates. We currently rely on our internal manufacturing facility for clinical manufacturing, and any disruption to this facility could impact our ability to advance our clinical trials. We currently rely on third parties for the manufacture of our **non- viral** vector and other components of our manufacturing process. These third ~~-~~ party manufacturers may incorporate their own proprietary processes into our components. We have limited control and oversight of a third party's proprietary process, and a third party may elect to modify its process without our consent or knowledge. These modifications could negatively impact our manufacturing, including product loss or failure that requires additional manufacturing runs or a change in manufacturer, both of which could significantly increase the cost of and significantly delay the manufacture of our product candidates. In addition, we are currently reliant on a single manufacturer for our transposon and transposase **components**, and many of the critical raw materials and reagents used in the process are single or sole source. These third ~~-~~ party providers may not be able to provide adequate resources, capacity to meet our needs, timely delivery of material, or may change internal processes or specifications that adversely affect our process or product candidates. Our manufacturing process is and will be susceptible to product loss or failure due to logistical issues, manufacturing issues associated with the differences in patients' white blood cells, interruptions in the manufacturing process or supply chain, contamination, equipment or reagent failure, process design flaws, operator error, power failures, supplier error and variability in patient characteristics. Even minor deviations from normal manufacturing processes could result in reduced production yields, product defects, product rejection, or other supply disruptions. If for any reason we lose a patient's white blood cells, such material gets contaminated or processing steps fail at any point, the manufacturing process of the TCR- ~~T~~ **therapy** candidate for that patient will need to be restarted, if possible, and the resulting delay may adversely affect that patient's outcome. If microbial, viral, or other contaminations are discovered in our product candidates or in the manufacturing facilities in which our product candidates or critical raw materials or reagents are made or administered, such manufacturing facilities may need to be closed for an extended period of time to investigate and remedy the contamination. As our product candidates progress through preclinical studies and clinical trials towards licensure and commercialization, it is expected that various aspects of the manufacturing and administration process will be altered in an effort to optimize processes and results. We have already identified some improvements to our manufacturing and administration processes, but these changes may not achieve the intended objectives, and could cause our product candidates to perform inadequately affecting the results of ongoing or future clinical trials. In addition, such changes may require amendments to be made to regulatory applications or necessitate development of new or additional TCR constructs and further clinical testing, which may further delay the timeframes under which modified manufacturing processes can be used for any of our product candidates. Developing a commercially viable process is a difficult and uncertain task, and there are risks associated with scaling to the level required for advanced clinical trials or commercialization, including, among others, increased costs, potential problems with process scale- out or scale- up, process reproducibility, stability issues, lot consistency, facility suitability or capacity, staffing, and availability of reagents or raw materials. Competitors have had difficulty reliably producing T cell

therapies in the commercial setting. If we experience similar challenges manufacturing product candidates to approved specifications, this may limit our product candidates' utilization and our ability to receive payment for these product candidates once approved. We may ultimately be unable to reduce the expenses associated with our product candidates to levels that will allow us to achieve a profitable return on investment. Although we have expanded our existing manufacturing facility and infrastructure in lieu of relying solely on third parties for the manufacture of our product candidates for certain clinical purposes and many of our personnel have experience in clinical manufacturing at other companies, we have **limited no direct** experience as a company managing manufacturing for our product candidates, which will be costly, time-consuming, and which may not be successful. We have expanded our existing manufacturing capacity to support our Phase 1 and Phase 2 clinical trials of our product candidates. We have **limited no prior** experience as a company in setting up, building or managing a manufacturing facility or manufacturing suite, and may never be successful in developing our own manufacturing suite, manufacturing facility or manufacturing capability. We will need to hire additional personnel to manage our operations and facilities and develop the necessary infrastructure to continue the research and development, and eventual commercialization, if licensed, of our product candidates. If we fail to recruit the required personnel, manage our growth effectively, have inadequate facility design or construction, or fail to select the correct location, the development and production of our product candidates could be curtailed or delayed. Although we have established a manufacturing facility, our manufacturing capabilities could be affected by cost-overruns, unexpected delays, equipment failures, design or construction flaws, labor shortages, supply disruptions, natural disasters, power failures and numerous other factors that could prevent us from realizing the intended benefits of our manufacturing strategy and have a material adverse effect on our business. In addition, the FDA, the European Medicines Agency (EMA), and other foreign regulatory authorities may require us to submit samples of any lot of any licensed product together with the protocols showing the results of applicable tests at any time. Under some circumstances, the FDA, the EMA or other foreign regulatory authorities may require that we not distribute a lot until the relevant agency authorizes its release. Slight deviations in the manufacturing process, including those affecting quality attributes and stability, may result in unacceptable changes in the product that could result in lot failures or product recalls, or inability to manufacture product in the future. Lot failures or product recalls could cause us to delay or forgo product launches or clinical trials, which could be costly to us and otherwise harm our business, financial condition, results of operations and prospects. Problems in our manufacturing process **or quality control testing** could restrict our ability to meet market demand for our product candidates. We also may encounter problems hiring and retaining the experienced scientific, quality-control and manufacturing personnel needed to operate our manufacturing processes and facility, which could result in delays in production or difficulties in maintaining compliance with applicable regulatory requirements. Any problems in our manufacturing process or facilities could make us a less attractive collaborator for potential partners, including larger pharmaceutical companies and academic research institutions, which could limit our access to additional attractive development programs. We may have difficulty validating our manufacturing process as we manufacture TCR- T ~~therapy~~ candidates from an increasingly diverse patient population for our clinical trials. As we develop our clinical products, we may encounter unforeseen difficulties due to quality, quantity, supply timing, or variability issues with donor starting materials and may not be able to develop a robust process or incur additional costs or delays in developing a robust process due to starting material variation or supply. Although we believe our current manufacturing process is scalable for commercialization, we may encounter challenges in validating our process due to the heterogeneity of the product starting material. While we anticipate that during the early phases of our clinical trials we will be able to adapt our process to account for these differences resulting in a more robust process, we cannot guarantee that issues relating to the heterogeneity of the starting material will not impact our ability to manufacture our product candidates for clinical or commercial distribution. The FDA regulatory approval process is lengthy and time-consuming, and we may experience significant delays in the clinical development and regulatory approval of our product candidates. We have not previously submitted a **Biologics License Application (BLA)** to the FDA or similar licensure applications to comparable foreign regulatory authorities. A BLA must include extensive preclinical and clinical data and supporting information to establish the product candidate's safety, purity, and potency for each desired indication. The BLA must also include significant information regarding the manufacturing controls for the product. We expect the novel nature of our product candidates to create further challenges in obtaining regulatory approval. Accordingly, the regulatory approval pathway for our product candidates may be uncertain, complex, expensive and lengthy, and licensure may not be obtained. We may also experience delays in completing planned clinical trials for a variety of reasons, including delays related to: • the availability of financial resources to commence and complete the planned trials; • obtaining approval at each clinical trial site by an IRB or ethics committee; • recruiting suitable patients to participate in a clinical trial; • having patients complete a clinical trial or return for post-treatment follow-up; • clinical trial sites deviating from trial protocol or dropping out of a trial; • adding new clinical trial sites; or • manufacturing sufficient quantities of qualified materials under cGMPs, including current Good Tissue Practices (cGTPs), and applying them on a subject **by** subject basis for use in clinical trials. We could also experience delays if physicians encounter unresolved ethical issues associated with enrolling patients in clinical trials of our product candidates in lieu of prescribing existing treatments that have established safety, efficacy, potency and purity profiles. Further, a clinical trial may be suspended or terminated by us, the IRBs for the institutions in which such trials are being conducted, the data monitoring committee for such trial, or by the FDA or other regulatory authorities due to a number of factors, including failure to conduct the clinical trial in accordance with regulatory requirements or our clinical protocols, inspection of the clinical trial operations or trial site by the FDA or other regulatory authorities resulting in the imposition of a clinical hold, unforeseen safety issues or adverse side effects, failure to demonstrate a benefit from using a product candidate, changes in governmental regulations or administrative actions or lack of adequate funding to continue the clinical trial. If we experience termination of, or delays in the completion of, any clinical trial of our product candidates, the commercial prospects for our product candidates will be harmed, and our ability to generate product revenue will be delayed. In addition, any delays in completing our clinical trials will increase our costs, slow down our product

development and approval process and jeopardize our ability to commence product sales and generate revenue. Securing regulatory approval also requires the submission of information about the biologic manufacturing process and inspection of manufacturing facilities by the relevant regulatory authority. The FDA or comparable foreign regulatory authorities may fail to approve our manufacturing processes or facilities, whether run by us or our third- party CMOs. In addition, if we make manufacturing changes to our product candidates in the future, we may need to conduct additional preclinical **studies** or clinical **studies-trials** to bridge our modified product candidates to earlier versions. Many of the factors that cause, or lead to, a delay in the commencement or completion of clinical trials may ultimately lead to the denial of regulatory approval of our product candidates. ~~We may be unable to obtain regulatory approval for our product candidates under applicable regulatory requirements. The denial or delay of any such approval would delay commercialization of our product candidates and adversely impact our potential to generate revenue, our business and our results of operations.~~ The research, testing, manufacturing, labeling, licensure, sale, marketing and distribution of biologic products are subject to extensive regulation by the FDA and other regulatory authorities in the **United States U. S.** and other countries, and such regulations differ from country to country. We are not permitted to market our product candidates in the **United States U. S.** or in any foreign countries until they receive the requisite licensure from the applicable regulatory authorities of such jurisdictions. The FDA or any foreign regulatory authorities can delay, limit or deny licensure of our product candidates for many reasons, including: • our inability to demonstrate to the satisfaction of the FDA or the applicable foreign regulatory authority that any of our product candidates are safe, potent and pure; • the FDA' s or the applicable foreign regulatory agency' s disagreement with our trial protocol or the interpretation of data from preclinical studies or clinical trials; • our inability to demonstrate that the clinical and other benefits of any of our product candidates outweigh any safety or other perceived risks; • the FDA' s or the applicable foreign regulatory agency' s requirement for additional preclinical studies or clinical trials; • the results of clinical trials may not meet the level of statistical significance required by the FDA or comparable foreign regulatory authorities for licensure; • the FDA' s or the applicable foreign regulatory agency' s failure to approve our manufacturing processes or facilities or those of third -party manufacturers upon which we rely; • the potential for approval policies or regulations of the FDA or the applicable foreign regulatory authorities to significantly change in a manner rendering our clinical data insufficient for licensure; • the data collected from clinical trials of our product candidates may not be sufficient to the satisfaction of the FDA or comparable foreign regulatory authorities to support the submission of a BLA or other comparable submission in foreign jurisdictions or to obtain licensure of our product candidates in the **United States U. S.** or elsewhere; or • the approval policies or regulations of the FDA or comparable foreign regulatory authorities may significantly change in a manner rendering our clinical data insufficient for approval. Any of these factors, many of which are beyond our control, may result in our failing to obtain regulatory approval to market any of our product candidates, which would significantly harm our business, results of operations, and prospects. Of the large number of biological products in development, only a small percentage successfully complete the FDA or other regulatory approval processes and are commercialized. Even if we eventually complete clinical testing and receive licensure from the FDA or applicable foreign regulatory authorities for any of our product candidates, the FDA or the applicable foreign regulatory agency may grant licensure contingent on the performance of costly additional clinical trials which may be required after licensure. The FDA or the applicable foreign regulatory agency also may license our product candidates for a more limited indication or a narrower patient population than we originally requested, and the FDA, or applicable foreign regulatory agency, may not license our product candidates with the labeling that we believe is necessary or desirable for the successful commercialization of such product candidates. In addition, even if the trials are successfully completed, preclinical and clinical data are often susceptible to varying interpretations and analyses, and we cannot guarantee that the FDA or comparable foreign regulatory authorities will interpret the results as we do, and more clinical trials could be required before we submit our product candidates for approval. To the extent that the results of the clinical trials are not satisfactory to the FDA or comparable foreign regulatory authorities for support of a marketing application, approval of our product candidates may be significantly delayed, or we may be required to expend significant additional resources, which may not be available to us, to conduct additional clinical trials in support of potential approval of our product candidates. Any delay in obtaining, or inability to obtain, applicable regulatory approval would delay or prevent commercialization of our product candidates and would materially adversely impact our business and prospects. We may seek orphan drug status for some of our current or future product candidates, but we may be unable to obtain such designations or to maintain the benefits associated with orphan drug status, including market exclusivity, which may cause our revenue, if any, to be reduced. Under the Orphan Drug Act, the FDA may grant orphan designation to a drug or biologic intended to treat a rare disease or condition, defined as a disease or condition with a patient population of fewer than 200, 000 in the **United States U. S.** , or a patient population greater than 200, 000 in the **United States U. S.** when there is no reasonable expectation that the cost of developing and making available the drug or biologic in the **United States U. S.** will be recovered from sales in the **United States U. S.** for that drug or biologic. Orphan drug designation must be requested before submitting a BLA. In the **United States U. S.** , orphan drug designation entitles a party to financial incentives such as opportunities for grant funding towards clinical trial costs, tax advantages and user- fee waivers. After the FDA grants orphan drug designation, the generic identity of the drug and its potential orphan use are disclosed publicly by the FDA. Orphan drug designation does not convey any advantage in, or shorten the duration of, the regulatory review and approval process. If a product that has orphan drug designation subsequently receives the first FDA approval for a particular active ingredient for the disease for which it has such designation, the product is entitled to orphan product exclusivity, which means that the FDA may not approve any other applications, including a BLA, to market the same biologic for the same indication for seven years, except in limited circumstances such as a showing of clinical superiority to the product with orphan drug exclusivity or if FDA finds that the holder of the orphan drug exclusivity has not shown that it can assure the availability of sufficient quantities of the orphan drug to meet the needs of patients with the disease or condition for which the drug was designated. As a result, even if one of our product candidates receives orphan exclusivity, the FDA can still approve other drugs that have a different active

ingredient for use in treating the same indication or disease. Furthermore, the FDA can waive orphan exclusivity if we are unable to manufacture sufficient supply of our product. We may seek orphan drug designation for some or all of our current or future product candidates in additional orphan indications in which there is a medically plausible basis for the use of these products. Even when we obtain orphan drug designation, exclusive marketing rights in the **United States U. S.** may be limited if we seek licensure for an indication broader than the orphan designated indication and may be lost if the FDA later determines that the request for designation was materially defective or if the manufacturer is unable to assure sufficient quantities of the product to meet the needs of patients with the rare disease or condition. In addition, although we intend to seek orphan drug designation for other product candidates, we may never receive such designations. On August 3, 2017, ~~the~~ Congress passed the FDA Reauthorization Act of 2017 (FDARA). FDARA, among other things, codified the FDA's pre-existing regulatory interpretation, to require that a drug sponsor demonstrate the clinical superiority of an orphan drug that is otherwise the same as a previously approved drug for the same rare disease in order to receive orphan drug exclusivity. The new legislation reverses prior precedent holding that the Orphan Drug Act unambiguously requires that the FDA recognize the orphan exclusivity period regardless of a showing of clinical superiority. Moreover, in the Consolidated Appropriations Act of 2021, Congress did not further change this interpretation when it clarified that the interpretation codified in FDARA would apply in cases where FDA issued an orphan designation before the enactment of FDARA but where product approval came after the enactment of FDARA. The FDA may further reevaluate the Orphan Drug Act and its regulations and policies. We do not know if, when, or how the FDA may change the orphan drug regulations and policies in the future, and it is uncertain how any changes might affect our business. Depending on what changes the FDA may make to its orphan drug regulations and policies, our business could be adversely impacted. A Breakthrough Therapy designation by the FDA, even if granted for any of our product candidates, may not lead to a faster development or regulatory review or approval process and it does not increase the likelihood that our product candidates will receive marketing approval. We plan to seek a Breakthrough Therapy designation for our current product candidates and may seek Breakthrough Therapy designation for some or all of our future product candidates. A **breakthrough Breakthrough therapy Therapy** is defined as a drug or biologic that is intended, alone or in combination with one or more other drugs or biologics, to treat a serious or life-threatening disease or condition and preliminary clinical evidence indicates that the drug, or biologic, may demonstrate substantial improvement over existing therapies on one or more clinically significant endpoints, such as substantial treatment effects observed early in clinical development. For product candidates that have been designated as **breakthrough Breakthrough therapies Therapies**, interaction and communication between the FDA and the sponsor of the trial can help to identify the most efficient path for clinical development while minimizing the number of patients placed in ineffective control regimens. Biologics designated as **breakthrough Breakthrough therapies Therapies** by the FDA may also be eligible for other expedited approval programs, including Accelerated Approval. Designation as a **breakthrough Breakthrough therapy Therapy** is within the discretion of the FDA. Accordingly, even if we believe one of our product candidates meets the criteria for designation as a **breakthrough Breakthrough therapy Therapy**, the FDA may disagree and instead determine not to make such designation. In any event, the receipt of a Breakthrough Therapy designation for a product candidate may not result in a faster development process, review or licensure compared to candidate products considered for licensure under non-expedited FDA review procedures and does not assure ultimate approval by the FDA. In addition, even if one or more of our product candidates qualify as **breakthrough Breakthrough therapies Therapies**, the FDA may later decide that the product no longer meets the conditions for qualification. Thus, even though we intend to seek Breakthrough Therapy designation for **TSC-100 and** some or all of our future product candidates for the treatment of various cancers, there can be no assurance that we will receive **breakthrough Breakthrough therapy Therapy** designation. A Fast Track designation by the FDA, even if granted for any of our current or future product candidates, may not lead to a faster development or regulatory review or approval process, and does not increase the likelihood that our product candidates will receive marketing approval. If a drug is intended for the treatment of a serious or life-threatening condition and the drug demonstrates the potential to address unmet medical needs for this condition, the drug sponsor may apply for FDA Fast Track designation for a particular indication. We plan to seek Fast Track designation for our current product candidates and may seek Fast Track designation for certain of our future product candidates, but there is no assurance that the FDA will grant this status to any of our proposed product candidates. Marketing applications filed by sponsors of products in Fast Track development may qualify for priority review under the policies and procedures offered by the FDA, but the Fast Track designation does not assure any such qualification or ultimate marketing approval by the FDA. The FDA has broad discretion whether or not to grant Fast Track designation, so even if we believe a particular product candidate is eligible for this designation, there can be no assurance that the FDA would decide to grant it. Even if we do receive Fast Track designation, we may not experience a faster development process, review or licensure compared to conventional FDA procedures, and receiving a Fast Track designation does not provide assurance of ultimate FDA approval. In addition, the FDA may withdraw Fast Track designation if it believes that the designation is no longer supported by data from our clinical development program. In addition, the FDA may withdraw any Fast Track designation at any time. We may seek **accelerated Accelerated approval Approval** from the FDA for any of our current or future product candidates. Accelerated **approval Approval**, even if granted, for any of our current or future product candidates, may not lead to a faster development, or regulatory review or approval process, and it does not increase the likelihood that our product candidates will receive marketing approval. We plan to seek approval of our current product candidates, and may seek approval of future product candidates using **the** FDA's **accelerated Accelerated approval Approval** pathway. A product may be eligible for **accelerated Accelerated approval Approval** if it treats a serious or life-threatening condition and generally provides a meaningful advantage over available therapies. In addition, it must demonstrate an effect on a surrogate endpoint that is reasonably likely to predict clinical benefit or on a clinical endpoint that can be measured earlier than irreversible morbidity or mortality (IMM) that is reasonably likely to predict an effect on IMM or other clinical benefit. As a condition of approval, the FDA may require that a sponsor of a drug or biologic receiving **accelerated Accelerated approval Approval** perform adequate

and well- controlled post- marketing clinical trials. These confirmatory trials must be completed with due diligence. In addition, the FDA currently requires, unless otherwise informed by the agency, pre- approval of promotional materials for products receiving ~~accelerated approval~~ **Accelerated approval Approval**, which could adversely impact the timing of the commercial launch of the product. Even if we do receive ~~accelerated approval~~ **Accelerated approval Approval**, we may not experience a faster development, regulatory review or approval process for that product. In addition, receiving ~~accelerated approval~~ **Accelerated approval Approval** does not provide assurance of ultimate FDA approval . **An RMAT designation by the FDA, even if granted for any of our product candidates, may not lead to a faster development or regulatory review or approval process, and does not increase the likelihood that our product candidates will receive marketing approval and we may be unable to obtain or maintain the benefits associated with such designation. We may seek an RMAT designation for some of our product candidates. An RMAT is defined as cell therapies, therapeutic tissue engineering products, human cell and tissue products, and combination products using any such therapies or products, except for those regulated solely under Section 361 of the Public Health Service Act. The RMAT program is intended to facilitate efficient development and expedite review of RMATs which are intended to treat, modify, reverse, or cure a serious or life- threatening disease or condition and where preliminary clinical evidence indicates the product has the potential to address unmet medical needs for such disease or condition. A BLA for an RMAT may be eligible for priority review if it meets the criteria for priority review, or for accelerated approval based on surrogate or intermediate endpoints reasonably likely to predict long- term clinical benefit or reliance upon data obtained from a meaningful number of sites. Benefits of RMAT designation include all the benefits of the Fast Track and Breakthrough Therapy designation programs, including early interactions with FDA, which could include interactions with FDA to discuss any potential surrogate or intermediate endpoint to be used to support accelerated approval. An RMAT that is granted accelerated approval and is subject to post- approval requirements may fulfill such requirements through the submission of clinical evidence, clinical studies, patient registries, or other sources of real- world evidence, such as electronic health records; the collection of larger confirmatory data sets; or post- approval monitoring of all patients treated with such therapy prior to its approval. RMAT designation is within the discretion of the FDA. Accordingly, even if we believe one of our product candidates meets the criteria for RMAT designation and seek RMAT designation for such product candidate, the FDA may disagree and instead determine not to make such designation. In any event, the receipt of RMAT designation for a product candidate may not result in a faster development, review or approval process compared to product candidates considered for approval under non- expedited FDA procedures and does not assure ultimate approval by the FDA. In addition, even if one or more of our product candidates qualify for RMAT designation, the FDA may later decide that the product candidate no longer meets the conditions for qualification .** We may seek designation for our TargetScan platform as a designated platform technology, but we might not receive such designation, and even if we do, such designation may not lead to a faster regulatory review or approval process. We may seek designation for our TargetScan platform as a designated platform technology. Under **the Food and Drug Omnibus Reform Act of 2022 (FDORA)**, a platform technology incorporated within or utilized by a biological product is eligible for designation as a designated platform technology if (1) the platform technology is incorporated in, or utilized by, a biological product approved under an BLA; (2) preliminary evidence submitted by the sponsor of the licensed biological product, or a sponsor that has been granted a right of reference to data submitted in the application for such biological product, demonstrates that the platform technology has the potential to be incorporated in, or utilized by, more than one biological product without an adverse effect on quality, manufacturing, or safety; and (3) data or information submitted by the applicable person indicates that incorporation or utilization of the platform technology has a reasonable likelihood to bring significant efficiencies to the biological product development or manufacturing process and to the review process. A sponsor may request the FDA to designate a platform technology as a designated platform technology concurrently with, or at any time after, submission of an IND application for a biological product that incorporates or utilizes the platform technology that is the subject of the request. If so designated, the FDA may expedite the development and review of any subsequent original BLA for a biological product that uses or incorporates the platform technology. Even if we believe our TargetScan platform technology meets the criteria for such designation, the FDA may disagree and instead determine not to grant such designation. In addition, the receipt of such designation for a platform technology does not ensure that a biological product will be developed more quickly or receive FDA approval. Moreover, the FDA may revoke a designation if the FDA determines that a designated platform technology no longer meets the criteria for such designation. Obtaining and maintaining regulatory approval of our product candidates in one jurisdiction does not mean that we will be successful in obtaining regulatory approval of our product candidates in other jurisdictions. Obtaining and maintaining regulatory approval of our product candidates in one jurisdiction does not guarantee that we will be able to obtain or maintain regulatory approval in any other jurisdiction, while a failure or delay in obtaining regulatory approval in one jurisdiction may have a negative effect on the regulatory approval process in others. For example, even if the FDA grants marketing approval of a product candidate, comparable regulatory authorities in foreign jurisdictions must also approve the manufacturing, marketing and promotion of the product candidate in those countries. Approval and licensure procedures vary among jurisdictions and can involve requirements and administrative review periods different from, and greater than, those in the ~~United States~~ **U. S.**, including additional preclinical studies or clinical trials as clinical trials conducted in one jurisdiction may not be accepted by regulatory authorities in other jurisdictions. In many jurisdictions outside the ~~United States~~ **U. S.**, a product candidate must be approved for reimbursement before it can be approved for sale in that jurisdiction. In some cases, the price that we intend to charge for any of our product candidates for which we receive marketing approval is also subject to approval. We may also submit marketing applications in other countries. Regulatory authorities in jurisdictions outside of the ~~United States~~ **U. S.** have requirements for approval of product candidates with which we must comply prior to marketing in those jurisdictions. Obtaining foreign regulatory approvals and compliance with foreign regulatory requirements could result in significant delays, difficulties

and costs for us and could delay or prevent the introduction of our product candidates in certain countries. If we fail to comply with the regulatory requirements in international markets and / or receive applicable marketing approvals, our target market will be reduced and our ability to realize the full market potential of our product candidates will be harmed. ~~In addition, we could face heightened risks with respect to seeking marketing approval in the United Kingdom as a result of the withdrawal of the United Kingdom from the European Union, commonly referred to as Brexit. The United Kingdom is no longer part of the European Single Market and European Union Customs Union. As of January 1, 2021, the Medicines and Healthcare products Regulatory Agency, or the MHRA, became responsible for supervising medicines and medical devices in Great Britain, comprising England, Scotland and Wales under domestic law, whereas Northern Ireland will continue to be subject to European Union rules under the Northern Ireland Protocol. The MHRA will rely on the Human Medicines Regulations 2012 (SI 2012/1916) (as amended), or the HMR, as the basis for regulating medicines. The HMR has incorporated into the domestic law of the body of European Union law instruments governing medicinal products that pre-existed prior to the United Kingdom's withdrawal from the European Union. Any delay in obtaining, or an inability to obtain, any marketing approvals, as a result of Brexit or otherwise, may force us to restrict or delay efforts to seek regulatory approval in the United Kingdom for our product candidates, which could significantly and materially harm our business. Furthermore, following the Brexit vote, the European Union moved the European Medicines Agency's headquarters from the United Kingdom to the Netherlands. This transition may cause disruption in the administrative and medical scientific links between the European Medicines Agency and the UK Medicines and Healthcare products Regulatory Agency, including delays in granting clinical trial authorization or marketing authorization, disruption of import and export of active substance and other components of new drug formulations and disruption of the supply chain for clinical trial product and final authorized formulations. The cumulative effects of the disruption to the regulatory framework may add considerably to the development lead time to marketing authorization and commercialization of products in the European Union and / or the United Kingdom.~~ Even if we receive regulatory approval of our product candidates, we will be subject to ongoing regulatory obligations and continued regulatory review, which may result in significant additional expense and we may be subject to penalties if we fail to comply with regulatory requirements or experience unanticipated problems with our product candidates. Any regulatory approvals that we receive for our product candidates will require surveillance to monitor the safety, potency and purity of the product candidate. The FDA may also require a risk evaluation and mitigation strategy in order to license our product candidates, which could entail requirements for a medication guide, physician communication plans or additional elements to ensure safe use, such as restricted distribution methods, patient registries and other risk minimization tools. In addition, if the FDA or a comparable foreign regulatory authority approves our product candidates, the manufacturing processes, labeling, packaging, distribution, adverse event reporting, storage, advertising, promotion, import, export and recordkeeping for our product candidates will be subject to extensive and ongoing regulatory requirements. These requirements include submissions of safety and other post-marketing information and reports, registration, as well as continued compliance with cGMPs, cGTPs and good clinical practices (GCPs) for any clinical trials that we conduct post-licensure. Manufacturers and manufacturers' facilities are required to comply with extensive FDA, and comparable foreign regulatory authority requirements, including ensuring that quality control and manufacturing procedures conform to cGMP regulations and applicable product tracking and tracing requirements. Later discovery of previously unknown problems with our product candidates, including adverse events of unanticipated severity or frequency, or with our manufacturing processes (or those of third parties we engage), or failure to comply with regulatory requirements, may result in, among other things: • restrictions on the marketing or manufacturing of our product candidates, withdrawal of the product from the market or voluntary or mandatory product recalls; • under FDORA, sponsors of approved drugs and biologics must provide 6 months' notice to the FDA of any changes in marketing status, such as the withdrawal of a product, and failure to do so could result in the FDA placing the product on a list of discontinued products, which would revoke the product's ability to be marketed; • revisions to the labeling, including limitation on approved uses or the addition of additional warnings, contraindications or other safety information, including boxed warnings; • imposition of a **Risk Evaluation and Mitigation Strategy (REMS)**, which may include distribution or use restrictions; • requirements to conduct additional post-market clinical trials to assess the safety of the product; • fines, warning letters or holds on clinical trials; • refusal by the FDA to approve pending applications or supplements to approved applications filed by us or suspension or revocation of license approvals; • product seizure or detention, or refusal to permit the import or export of our product candidates; and • injunctions or the imposition of civil or criminal penalties. The FDA's and other regulatory authorities' policies may change and additional government regulations may be enacted that could prevent, limit or delay regulatory approval of our product candidates. We cannot predict the likelihood, nature or extent of government regulation that may arise from future legislation or administrative action, either in the **United States U. S.** or abroad. If we are slow or unable to adapt to changes in existing requirements or the adoption of new requirements or policies, or if we are not able to maintain regulatory compliance, we may lose any marketing approval that we may have obtained and we may not achieve or sustain profitability. The insurance coverage and reimbursement status of newly-approved products **is are** uncertain. Our product candidates may become subject to unfavorable pricing regulations, third-party coverage and reimbursement practices, or healthcare reform initiatives, which would harm our business. Failure to obtain or maintain adequate coverage and reimbursement for new or current products could limit our ability to market those products and decrease our ability to generate revenue. The regulations that govern marketing approvals, pricing, coverage and reimbursement for new drugs vary widely from country to country. In the **United States U. S.**, recently enacted legislation may significantly change the approval requirements in ways that could involve additional costs and cause delays in obtaining approvals. Some countries require approval of the sale price of a drug before it can be marketed. In many countries, the pricing review period begins after marketing or product licensing approval is granted. In some foreign markets, prescription pharmaceutical pricing remains subject to continuing governmental control even after initial approval is granted. As a result, we might obtain marketing approval for a product in a particular country, but then be subject to price regulations that delay our

commercial launch of the product, possibly for lengthy time periods, and negatively impact the revenue we are able to generate from the sale of the product in that country. Adverse pricing limitations may hinder our ability to recoup our investment in one or more product candidates, even if any product candidates we may develop obtain marketing approval. **For more information, please see “ Item 1. Business – Government Regulation – Coverage and Reimbursement ” in this Annual Report.** In the ~~United States~~ **U. S.**, and markets in other countries, patients generally rely on third -party payors to reimburse all or part of the costs associated with their treatment. Adequate coverage and reimbursement from governmental healthcare programs, such as Medicare and Medicaid, and commercial payors is critical to new product acceptance. Our ability to successfully commercialize our product candidates will depend in part on the extent to which coverage and adequate reimbursement for these products and related treatments will be available from government health administration authorities, private health insurers and other organizations. Government authorities and other third -party payors, such as private health insurers and health maintenance organizations, decide which medications they will pay for and establish reimbursement levels. The availability of coverage and extent of reimbursement by governmental and private payors is essential for most patients to be able to afford treatments such as cell therapy products. Sales of these or other product candidates that we may identify will depend substantially, both domestically and abroad, on the extent to which the costs of our product candidates will be paid by health maintenance, managed care, pharmacy benefit and similar healthcare management organizations, or reimbursed by government health administration authorities, private health coverage insurers and other third -party payors. If coverage and adequate reimbursement **is-are** not available, or **is-are** available only to limited levels, we may not be able to successfully commercialize our product candidates. Even if coverage is provided, the approved reimbursement amount may not be high enough to allow us to establish or maintain pricing sufficient to realize a sufficient return on our investment. Reimbursement by a third -party payor may depend upon a number of factors, including, but not limited to, the third -party payor’s determination that use of a product is: **• a covered benefit under its health plan; • safe, effective and medically necessary; • appropriate for the specific patient; • cost-effective; and • neither experimental nor investigational.** A primary trend in the U. S. healthcare industry and elsewhere is cost containment. Government authorities and third -party payors have attempted to control costs by limiting coverage and the amount of reimbursement for particular medications. In many countries, the prices of medical products are subject to varying price control mechanisms as part of national health systems. In general, the prices of medicines under such systems are substantially lower than in the ~~United States~~ **U. S.** Other countries allow companies to fix their own prices for medicines, but monitor and control company profits. Additional foreign price controls or other changes in pricing regulation could restrict the amount that we are able to charge for our product candidates. Accordingly, in markets outside the ~~United States~~ **U. S.**, the reimbursement for products may be reduced compared with the ~~United States~~ **U. S.** and may be insufficient to generate commercially reasonable revenues and profits. There is also significant uncertainty related to the insurance coverage and reimbursement of newly approved products and coverage may be more limited than the purposes for which the medicine is approved by the FDA or comparable foreign regulatory authorities. In the ~~United States~~ **U. S.**, the principal decisions about reimbursement for new medicines are typically made by ~~Centers for Medicare & Medicaid Services, or~~ CMS, an agency within ~~the~~ HHS. CMS decides whether and to what extent a new medicine will be covered and reimbursed under Medicare and private payors tend to follow CMS to a substantial degree. No uniform policy of coverage and reimbursement for products exists among third -party payors and coverage and reimbursement levels for products can differ significantly from payor to payor. As a result, the coverage determination process is often a time consuming and costly process that may require us to provide scientific and clinical support for the use of our product candidates to each payor separately, with no assurance that coverage and adequate reimbursement will be applied consistently or obtained in the first instance. It is difficult to predict what CMS will decide with respect to reimbursement for fundamentally novel products such as ours. Reimbursement agencies in Europe may be more conservative than CMS. For example, a number of cancer drugs have been approved for reimbursement in the ~~United States~~ **U. S.** and have not been approved for reimbursement in certain European countries. Moreover, eligibility for reimbursement does not imply that any drug will be paid for in all cases or at a rate that covers our costs, including research, development, manufacture, sale, and distribution. Interim reimbursement levels for new drugs, if applicable, may also not be sufficient to cover our costs and may not be made permanent. Reimbursement rates may vary according to the use of the drug and the clinical setting in which it is used, may be based on reimbursement levels already set for lower cost drugs and may be incorporated into existing payments for other services. Our inability to promptly obtain coverage and profitable payment rates from both government- funded and private payors for any approved products we may develop could have a material adverse effect on our operating results, our ability to raise capital needed to commercialize product candidates, and our overall financial condition. Net prices for drugs may be reduced by mandatory discounts or rebates required by government healthcare programs or private payors and by any future relaxation of laws that presently restrict imports of drugs from countries where they may be sold at lower prices than in the ~~U~~ **United States**. **S. Increasingly, Our inability to promptly obtain coverage and profitable reimbursement rates third -party payors for any approved products that we develop could have a material adverse effect on our operating results, our ability to raise capital needed to commercialize products and our overall financial condition. Increasingly, third -party payors are requiring that drug companies provide them with predetermined discounts from list prices and are challenging the prices charged for medical products. We cannot be sure that reimbursement will be available for any product candidate that we commercialize and, if reimbursement is available, the level of reimbursement.** **In addition, many pharmaceutical manufacturers must calculate and report certain price reporting metrics to the government, such as average sales price, or ASP, and best price. Penalties may apply in some cases when such metrics are not submitted accurately and timely. Further, these prices for drugs may be reduced by mandatory discounts or rebates required by government healthcare programs. We cannot be sure that reimbursement will be available for any product candidate that we commercialize and, if reimbursement is available, the level of reimbursement.** Reimbursement may impact the demand for, or the price of, any product candidate for which we obtain marketing approval. In order to obtain reimbursement,

physicians may need to show that patients have superior treatment outcomes with our product candidates compared to standard of care drugs, including lower- priced biosimilar versions of standard of care drugs. We expect to experience pricing pressures in connection with the sale of any of our product candidates due to the trend toward managed healthcare, the increasing influence of health maintenance organizations and additional legislative changes. The downward pressure on healthcare costs in general, particularly prescription drugs and surgical procedures and other treatments, has become very intense. As a result, increasingly high barriers are being erected to the entry of new products. The impact of recent healthcare reform legislation and other changes in the healthcare industry and in healthcare spending on us is currently unknown, and may adversely affect our business model. Our revenue prospects could be affected by changes in healthcare spending and policy in the ~~United States U. S.~~ and abroad. We operate in a highly regulated industry and new laws, regulations or judicial decisions, or new interpretations of existing laws, regulations or decisions, related to healthcare availability, the method of delivery or payment for healthcare products and services could negatively impact our business, operations and financial condition. For more information, please see “**Item 1. Business – Government Regulation – Healthcare Legislative Reform –**” **in this Annual Report.** There have been, and likely will continue to be, legislative and regulatory proposals at the foreign, federal and state levels directed at broadening the availability of healthcare and containing or lowering the cost of healthcare. We cannot predict the initiatives that may be adopted in the future, including repeal, replacement or significant revisions to the Affordable Care Act. The continuing efforts of the government, insurance companies, managed care organizations and other payors of healthcare services to contain or reduce costs of healthcare and / or impose price controls may adversely affect: • the demand for our product candidates, if we obtain regulatory approval; • our ability to set a price that we believe is fair for our product candidates; • our ability to obtain coverage and reimbursement approval for a product candidate; • our ability to generate revenue and achieve or maintain profitability; • the level of taxes that we are required to pay; and • the availability of capital. Any reduction in reimbursement from Medicare or other government programs may result in a similar reduction in payments from private payors, which may adversely affect our future profitability. **We expect that the healthcare reform measures that have been adopted and may be adopted in the future, may result in more rigorous coverage criteria and in additional downward pressure on the price that we receive for any approved product and could seriously harm our future revenues. Any reduction in reimbursement from Medicare or other government programs may result in a similar reduction in payments from private payors. The implementation of cost containment measures or other healthcare reforms may prevent us from being able to generate revenue, attain profitability or commercialize our products.** Regulatory requirements in the ~~United States U. S.~~ and abroad governing cell therapy products have changed frequently and may continue to change in the future, which could negatively impact our ability to complete clinical trials and commercialize our product candidates in a timely manner, if at all. Regulatory requirements in the ~~United States U. S.~~ and abroad governing cell therapy products have changed frequently and may continue to change in the future. The FDA has established an office, now called the Office of Therapeutic Products within its Center for Biologics Evaluation and Research to meet its growing cell and gene therapy workload. The FDA also established the Cellular, Tissue and Gene Therapies Advisory Committee to advise its review. Inadequate funding for the FDA, the SEC and other government agencies could hinder their ability to hire and retain key leadership and other personnel, prevent new products and services from being developed or commercialized in a timely manner or otherwise prevent those agencies from performing normal business functions on which the operation of our business may rely, which could negatively impact our business. The ability of the FDA to review and approve new products can be affected by a variety of factors, including government budget and funding levels, ability to hire and retain key personnel and accept the payment of user fees, and statutory, regulatory, and policy changes. Average review times at the agency have fluctuated in recent years as a result. In addition, government funding of the SEC and other government agencies on which our operations may rely, including those that fund research and development activities is subject to the political process, which is inherently fluid and unpredictable. Disruptions at the FDA and other agencies may also slow the time necessary for new drugs to be reviewed and / or approved by necessary government agencies, which would adversely affect our business. For example, over the last several years the U. S. government has shut down several times and certain regulatory agencies, such as the FDA and the SEC, have had to furlough critical FDA, SEC and other government employees and stop critical activities. If a prolonged government shutdown occurs, it could significantly impact the ability of the FDA to timely review and process our regulatory submissions, which could have a material adverse effect on our business. Further, in our operations as a public company, future government shutdowns could impact our ability to access the public markets and obtain necessary capital in order to properly capitalize and continue our operations. ~~Since March 2020 when foreign and domestic inspections of facilities were largely placed on hold, the FDA has been working to resume pre-pandemic levels of inspection activities, including routine surveillance, bioresearch monitoring and pre-approval inspections. Should FDA determine that an inspection is necessary for approval and an inspection cannot be completed during the review cycle due to restrictions on travel, and the FDA does not determine a remote interactive evaluation to be adequate, the agency has stated that it generally intends to issue, depending on the circumstances, a complete response letter or defer action on the application until an inspection can be completed. During the COVID-19 public health emergency, a number of companies announced receipt of complete response letters due to the FDA’s inability to complete required inspections for their applications. Regulatory authorities outside the U. S. may adopt similar restrictions or other policy measures in response to the ongoing COVID-19 pandemic and may experience delays in their regulatory activities.~~ Our employees, independent contractors, consultants, commercial partners and vendors may engage in misconduct or other improper activities, including noncompliance with regulatory standards and requirements. We are exposed to the risk of employee fraud or other illegal activity by our employees, independent contractors, consultants, commercial partners and vendors. Misconduct by these parties could include intentional, reckless and / or negligent conduct that fails to: comply with the regulations of the FDA and other similar foreign regulatory authorities, provide true, complete and accurate information to the FDA and other similar foreign regulatory authorities, comply with manufacturing standards we have established, comply with healthcare fraud and abuse laws in the ~~United States U. S.~~ and

similar foreign fraudulent misconduct laws or report financial information or data accurately or to disclose unauthorized activities to us. If we obtain FDA approval of any of our product candidates and begin commercializing those products in the **United States U. S.**, our potential exposure under such laws and regulations will increase significantly, and our costs associated with compliance with such laws and regulations are also likely to increase. These laws may impact, among other things, our current activities with principal investigators and research patients, as well as proposed and future sales, marketing and education programs. In particular, the promotion, sales and marketing of healthcare items and services, as well as certain business arrangements in the healthcare industry, are subject to extensive laws designed to prevent fraud, kickbacks, self-dealing and other abusive practices. These laws and regulations may restrict or prohibit a wide range of pricing, discounting, marketing and promotion, structuring and commission (s), certain customer incentive programs and other business arrangements generally. Activities subject to these laws also involve the improper use of information obtained in the course of patient recruitment for clinical trials. For more information, please see “**Item 1. Business – Government Regulation – Anti- Kickback and False Claims Laws and Other Regulatory Matters –**” **in this Annual Report.** Additionally, we are subject to state and foreign equivalents of each of the healthcare laws described above, among others, some of which may be broader in scope and may apply regardless of the payor. We have adopted a code of business conduct and ethics, but it is not always possible to identify and deter employee misconduct, and the precautions we take to detect and prevent inappropriate conduct may not be effective in controlling unknown or unmanaged risks or losses or in protecting us from governmental investigations or other actions or lawsuits stemming from a failure to be in compliance with such laws or regulations. Efforts to ensure that our business arrangements with third parties will comply with applicable healthcare laws and regulations will involve substantial costs. Because of the breadth of these laws and the narrowness of the statutory exceptions and safe harbors available, it is possible that some of our business activities could be subject to challenge under one or more of such laws. It is possible that governmental authorities will conclude that our business practices may not comply with current or future statutes, regulations or case law involving applicable fraud and abuse or other healthcare laws and regulations. If our operations are found to be in violation of any of these laws or any other governmental regulations that may apply to us, we may be subject to significant criminal, civil and administrative sanctions including monetary penalties, damages, fines, disgorgement, individual imprisonment, and exclusion from participation in government funded healthcare programs, such as Medicare and Medicaid, additional reporting requirements and oversight if we become subject to a corporate integrity agreement or similar agreement to resolve allegations of non-compliance with these laws, reputational harm, and we may be required to curtail or restructure our operations, any of which could adversely affect our ability to operate our business and our results of operations. The risk of our being found in violation of these laws is increased by the fact that many of them have not been fully interpreted by the regulatory authorities or the courts, and their provisions are open to a variety of interpretations. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and divert our management’s attention from the operation of our business. The shifting compliance environment and the need to build and maintain robust and expandable systems to comply with multiple jurisdictions with different compliance and / or reporting requirements increases the possibility that a healthcare company may run afoul of one or more of the requirements. The provision of benefits or advantages to physicians to induce or encourage the prescription, recommendation, endorsement, purchase, supply, order or use of medicinal products is also prohibited in the EU. The provision of benefits or advantages to ~~physicians~~ **induce or reward improper performance generally** is governed by the national anti- bribery laws of EU Member States ~~and~~, ~~such as the U. K. Bribery Act 2010 (~~~~or the Bribery Act)~~ **in the UK**. Infringement of these laws could result in substantial fines and imprisonment. Payments made to physicians in certain EU Member States must be publicly disclosed. **EU Directive 2001 / 83 / EC, which is the EU Directive governing medicinal products for human use, further provides that, where medicinal products are being promoted to persons qualified to prescribe or supply them, no gifts, pecuniary advantages or benefits in kind may be supplied, offered or promised to such persons unless they are inexpensive and relevant to the practice of medicine or pharmacy. This provision has been transposed into the Human Medicines Regulations 2012 and so remains applicable in the UK despite its departure from the EU.** Moreover, agreements with physicians often must be the subject of prior notification and approval by the physician’s employer, his or her competent professional organization and / or the regulatory authorities of the individual EU Member States. These requirements are provided in the national laws, industry codes or professional codes of conduct, applicable in the EU Member States. Failure to comply with these requirements could result in reputational risk, public reprimands, administrative penalties, fines or imprisonment. We are currently subject to, and may in the future become subject to additional, federal, state and foreign laws and regulations, industry guidelines, and contractual requirements, imposing obligations on how we collect, store, use and process personal information. Our actual or perceived failure to comply with such obligations could harm our business. Ensuring compliance with such laws could also impair our efforts to maintain and expand our customer base, and thereby decrease our revenue. We are, and may increasingly become, subject to various laws and regulations, as well as contractual obligations and mandatory industry standards relating to privacy and security in the jurisdictions in which we operate. The regulatory environment related to data privacy and security is increasingly rigorous, with new and constantly changing requirements applicable to our business, and enforcement practices are likely to remain uncertain for the foreseeable future. These laws and regulations may be interpreted and applied differently over time and from jurisdiction to jurisdiction, and it is possible that they will be interpreted and applied in ways that may have a material adverse effect on our business, financial condition, results of operations and prospects. In the **United States U. S.**, various federal and state regulators, including governmental agencies like the Federal Trade Commission, have adopted, or are considering adopting, laws and regulations concerning personal information and data security. Certain state laws may be more stringent or broader in scope, or offer greater individual rights, with respect to personal information than federal, international or other state laws, and such laws may differ from each other, all of which may complicate compliance efforts. For example, the California Consumer Privacy Act ~~(of 2018, or CCPA , which)~~ **as amended by the California Privacy Rights Act (CPRA)**

increases -- **creates individual** privacy rights for California residents and imposes obligations on companies that process their personal information and meet certain revenue or volume processing thresholds, ~~came into effect on January 1, 2020, and was further amended by the California Privacy Rights Act (CPRA), which became effective on January 1, 2023.~~ Among other things, the CCPA requires covered companies to provide new disclosures to California residents and provide such residents **with** new data protection and privacy rights, including the ability to opt- out of certain sales of personal information. The amendments introduced by the CPRA significantly ~~modifies~~ **modify** the CCPA by expanding residents' rights with respect to certain personal information and creates a new state agency to oversee implementation and enforcement efforts, among other changes. The CCPA provides for civil penalties for violations, as well as a private right of action for certain data breaches. This private right of action may increase the likelihood of, and risks associated with, data breach litigation, including class action litigation. Similar laws have been passed in **numerous other states** ~~Connecticut, Colorado, Utah and Virginia~~ and a number of other states have proposed new privacy laws, some of which are similar to the above discussed recently passed laws. Such proposed legislation, if enacted, may add additional complexity, variation in requirements, restrictions and potential legal risk, require additional investment of resources in compliance programs, impact strategies and the availability of previously useful data and could result in increased compliance costs and / or changes in business practices and policies. The existence of comprehensive privacy laws in different states in the country would make our compliance obligations more complex and costly and may increase the likelihood that we may be subject to enforcement actions or otherwise incur liability for noncompliance. In addition, laws in all 50 U. S. states require businesses to provide notice to individuals if certain of their personal information has been disclosed as a result of a qualifying data breach . **There are also states that are specifically regulating health information. For example, Washington state recently passed a health privacy law that will regulate the collection and sharing of health information, and the law also has a private right of action, which further increases the relevant compliance risk. Connecticut and Nevada have also passed similar laws regulating consumer health data. In addition, other states have proposed and / or passed legislation that regulates the privacy and / or security of certain specific types of information. For example, a small number of states have passed laws that regulate biometric data specifically. These various privacy and security laws may impact our business activities, including our identification of research subjects, relationships with business partners and ultimately the marketing and distribution of our products .** State laws are changing rapidly and there is discussion in the U. S. Congress of a new comprehensive federal data privacy law to which we may likely become subject, if enacted. Internationally, laws, regulations and standards in many jurisdictions apply broadly to the collection, use, retention, security, disclosure, transfer, marketing or other processing of personal data. For example, the collection, use, storage, disclosure, transfer, or other processing of personal data regarding individuals in the EEA, including personal health data, is subject to the EU General Data Protection Regulation 2016 / 679 ("GDPR "), which became effective on May 25, 2018. The GDPR is wide- ranging in scope and imposes numerous requirements on companies that process personal data, including requirements relating to **having a legal basis for processing health and personal data, stricter requirements relating to** ~~other~~ **the processing of** sensitive data (such as health data) , **where required by GDPR** obtaining consent of the individuals to whom the personal data relates, providing information to individuals regarding data processing activities, implementing safeguards to protect the security and confidentiality of personal data, providing notification of data breaches, **requirements to conduct data protection impact assessments for high risk processing** and taking certain measures when engaging third- party processors. The GDPR permits data protection authorities to impose large penalties for violations of the GDPR, including potential fines of up to € 20 million or 4 % of annual global revenues, whichever is greater. The GDPR also confers a private right of action on data subjects and consumer associations to lodge complaints with supervisory authorities, seek judicial remedies, and obtain compensation for damages resulting from violations of the GDPR. The GDPR increased our responsibility and liability in relation to personal data that we process where such processing is subject to the GDPR, and we may be required to put in place additional mechanisms to ensure compliance with the GDPR, including as implemented by individual countries. Compliance with the GDPR will be a rigorous and time- intensive process that may increase our cost of doing business or require us to change our business practices, and despite those efforts, there is a risk that we may be subject to fines and penalties, litigation, and reputational harm in connection with our European activities. The GDPR provides that EEA Member States may make their own further laws and regulations in relation to the processing of genetic, biometric or health data, which could result in differences between **EEA** Member States, limit our ability to use and share personal data or could cause our costs to increase, and harm our business and financial condition. **The Significantly, the** GDPR ~~also~~ imposes strict rules on the transfer of personal data **out of the EEA and UK** to ~~countries~~ **other regions** outside the EEA / UK , **or including the United States.** ~~We are subject to evolving and strict rules on the transfer of personal data out of the EEA to third countries , that have not been deemed to offer " adequate " privacy protections by the competent data protection authorities, including the U. S. in certain circumstances, unless a derogation exists or adequate international transfer safeguards are put in place,~~ such as the United States. ~~Unless the destination country is an adequate country (as recognized by the European Commission).~~ **for example,** we will be required to incorporate a GDPR transfer mechanism (such as the European Commission approved ~~standard~~ **Standard contractual** ~~Contractual~~ **clauses** ~~Clauses~~ ("~~the EU SCCs~~ ") **and the UK International Data Transfer Agreement / Addendum (the UK IDTA)** into . ~~Where relying on the EU SCCs~~ **our** ~~or UK IDTA for data~~ **agreements with third parties to govern** transfers , **we** of personal data outside the EEA. The new SCCs may also impact our business as companies based in the EEA may be reluctant **required** to **carry out** utilize the new clauses to legitimize transfers of personal data to third countries given the burdensome requirements of transfer impact assessments **on the transfers made pursuant to the EU SCCs and UK IDTA, on a case- by- case basis, to ensure the law in the recipient country provides " essentially equivalent " protections to safeguard the transferred personal data as provided in the EEA and UK, and may be required to adopt supplementary measures if this standard is not met. Further, the EU and the U. S. have adopted its adequacy decision for the EU- U. S. Data Privacy Framework (" Framework"), which entered into force on July 11,**

2023. This Framework provides that the protection of personal data transferred between the EU and the U. S. is comparable to that offered in the EU. This provides a further avenue to ensuring transfers to the U. S. are carried out in line with GDPR. There has been and an extension to the substantial Framework to cover UK transfers to the U. S. The Framework could be challenged like its predecessor frameworks. The international transfer obligations that under the EEA and new SCCs impose upon exporters. In addition, further to the UK's exit from the EU on January 31, 2020 the UK's European Union (Withdrawal) Act 2018 incorporated the GDPR into UK law, referred to as the UK GDPR. The UK GDPR and the UK Data Protection Act 2018 set out the UK's data protection regime regimes, will require significant effort and cost and may result in us needing to make strategic considerations around where EEA and UK personal data is located and which is independent service providers we can utilize for the processing of EEA and UK personal data. Any inability to transfer personal data from but currently still aligned to the EU's EEA to the U. S. in compliance with data protection laws regime. Non-compliance with the UK GDPR may impede result in monetary penalties of up to £17.5 million or our 4% of worldwide revenue, whichever is higher ability to conduct trials and may adversely affect our business and financial position. Although the UK is regarded as a one of the third country countries under the EU's GDPR, the European Commission has now issued a adopted an adequacy decision recognizing in favor of the UK as providing adequate protection under the EU GDPR and, enabling therefore, transfers of personal data originating in the EU to the UK remain unrestricted. Like the EU GDPR, the UK GDPR restricts personal data transfers outside from EEA member states to the UK without additional safeguards to countries not regarded by the UK as providing adequate protection. It is not subject to the new forms of SCCs but has issued its own transfer mechanism—the UK international data transfer agreement—which, like the SCCs, requires exporters to carry out a transfer impact assessment. The UK government has confirmed that personal data transfers from the UK to the EEA remain free flowing. The UK Government has also now introduced a Data Protection and Digital Information Bill (or the UK Bill) into the UK legislative process with. The aim of the UK intention for this bill Bill is to reform the UK's data protection regime following Brexit. If passed, the final version of the UK Bill may will make changes to the UK GDPR. In addition, EEA Member States have adopted national laws to implement the effect GDPR that may partially deviate from the GDPR. Further, the competent authorities in the EEA Member States may interpret GDPR obligations slightly differently from country to country and therefore we do not expect to operate in a uniform legal landscape in the EEA. Further, the competent authorities in the EEA Member States may interpret the EU GDPR obligations slightly differently from country to country and therefore we do not expect to operate in a uniform legal landscape in the EEA. The potential of the respective provisions and enforcement of the EU GDPR and UK GDPR further altering diverging in the future creates similarities between the UK and EU data protection regime and threaten the UK Adequacy Decision from the EU Commission. This may lead to additional compliance costs regulatory challenges and uncertainties for us could increase our overall risk. All of these evolving compliance and operational requirements impose significant costs, such as costs related to organizational changes, implementing additional protection technologies, training employees and engaging consultants and legal advisors, which are likely to increase over time. In addition, such requirements may require us to modify our data processing practices and policies, utilize management's time and / or divert resources from other initiatives and projects. Any failure or perceived failure by us to comply with any applicable federal, state or foreign laws and regulations relating to data privacy and security could result in damage to our reputation, as well as proceedings or litigation by governmental agencies or other third parties, including class action privacy litigation in certain jurisdictions, which would subject us to significant fines, sanctions, awards, injunctions, penalties or judgments. Any of the foregoing could have a material adverse effect on our business, financial condition, results of operations and prospects. If we fail to comply with environmental, health and safety laws and regulations, we could become subject to fines or penalties or incur costs that could have a material adverse effect on the success of our business. We are subject to numerous environmental, health and safety laws and regulations, including those governing laboratory procedures and the handling, use, storage, treatment and disposal of hazardous materials and wastes. Our operations involve the use of hazardous and flammable materials, including chemicals and biological and radioactive materials. Our operations also produce hazardous waste products. We generally contract with third parties for the disposal of these materials and wastes. We cannot eliminate the risk of contamination or injury from these materials. In the event of contamination or injury resulting from our use of hazardous materials, we could be held liable for any resulting damages, and any liability could exceed our resources. We also could incur significant costs associated with civil or criminal fines and penalties. Although we maintain workers' compensation insurance to cover us for costs and expenses we may incur due to injuries to our employees resulting from the use of hazardous materials, this insurance may not provide adequate coverage against potential liabilities. We do not maintain insurance for environmental liability or toxic tort claims that may be asserted against us in connection with our storage or disposal of biological, hazardous or radioactive materials. Even if we are able to commercialize any product candidates, the products may become subject to unfavorable pricing regulations, third party reimbursement practices or healthcare reform initiatives, which would harm our business. The regulations that govern marketing approvals, pricing, coverage and reimbursement for new drug products vary widely from country to country. Current and future legislation may significantly change the approval requirements in ways that could involve additional costs and cause delays in obtaining approvals. Some countries require approval of the sale price of a drug before it can be marketed. In many countries, the pricing review period begins after marketing or product licensing approval is granted. To obtain reimbursement or pricing approval in some countries, we may be required to conduct a clinical trial that compares the cost-effectiveness of our product candidate to other available therapies. In some foreign markets, prescription pharmaceutical pricing remains subject to continuing governmental control even after initial approval is granted. As a result, we might obtain marketing approval for a product candidate in a particular country, but then be subject to price regulations that delay our commercial launch of the product, possibly for lengthy time periods, and negatively impact the revenues, if any, we are able to generate from the sale of the product in that country. Adverse pricing limitations may hinder our ability to recoup our investment in one or more product

candidates, even if our product candidates obtain marketing approval. For more information, please see “**Item 1. Business – Government Regulation – Coverage and Reimbursement –**” **in this Annual Report.** Our ability to commercialize any product candidates successfully also will depend in part on the extent to which coverage and adequate reimbursement for these products and related treatments will be available from government healthcare programs, private health insurers and other organizations. Government authorities and third-party payors, such as private health insurers and health maintenance organizations, decide which medications they will pay for and establish reimbursement levels. A primary trend in the U. S. healthcare industry and elsewhere is cost containment. Government authorities and third-party payors have attempted to control costs by limiting coverage and the amount of reimbursement for particular medications. Increasingly, government authorities and third-party payors are requiring that drug companies provide them with predetermined discounts from list prices and are challenging the prices charged for medical products. Coverage and reimbursement may not be available for any product that we commercialize and, even if these are available, the level of reimbursement may not be satisfactory. Reimbursement may affect the demand for, or the price of, any product candidate for which we obtain marketing approval. Obtaining and maintaining adequate reimbursement for our product candidates may be difficult. We may be required to conduct expensive pharmacoeconomic studies to justify coverage and reimbursement or the level of reimbursement relative to other therapies. If coverage and adequate reimbursement are not available or reimbursement is available only to limited levels, we may not be able to successfully commercialize any product candidate for which we obtain marketing approval. There may be significant delays in obtaining coverage and reimbursement for newly approved drugs, and coverage may be more limited than the purposes for which the drug is approved by the FDA or similar regulatory authorities outside of the **United States-U. S.** Moreover, eligibility for coverage and reimbursement does not imply that a drug will be paid for in all cases or at a rate that covers our costs, including research, development, intellectual property, manufacture, sale and distribution expenses. Interim reimbursement levels for new drugs, if applicable, may also not be sufficient to cover our costs and may not be made permanent. Reimbursement rates may vary according to the use of the drug and the clinical setting in which it is used, may be based on reimbursement levels already set for lower cost drugs and may be incorporated into existing payments for other services. Net prices for drugs may be reduced by mandatory discounts or rebates required by government healthcare programs or private payors and by any future relaxation of laws that presently restrict imports of drugs from countries where they may be sold at lower prices than in the **United States-U. S.** Third-party payors often rely upon Medicare coverage policy and payment limitations in setting their own reimbursement policies. Our inability to promptly obtain coverage and adequate reimbursement rates from both government-funded and private payors for any approved products that we develop could have a material adverse effect on our operating results, our ability to raise capital needed to commercialize products and our overall financial condition. ~~If we are unable to obtain and maintain patent protection for any product candidates we develop and for our technology, or if the scope of the patent protection obtained is not sufficiently broad, our competitors could develop and commercialize products, product candidates and technology similar or identical to ours, and our ability to successfully commercialize any product candidates we may develop, and our technology may be adversely affected.~~ Our success will depend in large part on our ability and the ability of our licensors and collaborators to obtain and maintain patent protection and other intellectual property and proprietary rights in the **United States-U. S.** and other countries with respect to our technology and our product candidates, their respective components, formulations, combination therapies, methods used to manufacture them and methods of treatment and development that are important to our business, as well as, our ability to operate our business without infringing, misappropriating or otherwise violating the intellectual property rights of others. Given the early stage of development of our product candidates, our patent portfolio is similarly at ~~an a very~~ early stage. In particular, we do not exclusively license any issued patents and ~~most many~~ of the patent applications we own are provisional applications. If we do not obtain meaningful patent coverage for our product candidates, their respective components, formulations, combination therapies, methods used to manufacture them and methods of treatment, competitors may be able to erode or negate any competitive advantage we may have, which would likely harm our business and ability to achieve profitability. To establish our proprietary position, we have filed provisional patent applications and corresponding Patent Cooperation Treaty (PCT), national, and regional applications related to our novel product candidates that are important to our business, and we have exclusively licensed ~~certain a~~ patent **applications family** from **The Brigham and Women’s Hospital, Inc. (or-BWH)**; we may in the future also license or purchase issued patents or pending patent applications filed by others. U. S. provisional patent applications are not eligible to become issued patents until, among other things, we file a non-provisional patent application within 12 months of filing of one or more of our related provisional patent applications. With regard to such U. S. provisional patent applications, if we do not timely file any non-provisional patent applications, we may lose our priority date with respect to our provisional patent applications and any patent protection on the inventions disclosed in our provisional patent applications. While we intend to timely file non-provisional patent applications relating to our provisional patent applications, we cannot predict whether any such patent applications will result in the issuance of patents that provide us with any competitive advantage. If we are unable to secure or maintain patent protection with respect to our antibody technology and any proprietary products and technology we develop, our business, financial condition, results of operations, and prospects could be materially harmed. If the scope of the patent protection we or our existing and potential licensors obtain, if any, is not sufficiently broad, we may not be able to prevent others from developing and commercializing technology and products similar or identical to ours. The degree of patent protection we require to successfully compete in the marketplace may be unavailable or severely limited and may not adequately protect our business or permit us to gain or keep any competitive advantage. We cannot provide any assurances that any of our owned or exclusively licensed pending patent applications that mature into issued patents will include claims with a scope sufficient to protect our current and future product candidates or otherwise provide any competitive advantage. In addition, to the extent that we license intellectual property now or in the future, we cannot provide any assurances that those licenses will remain in force. In addition, the laws of foreign countries may not protect our rights to the same extent as the laws of the **United States-U. S.** Furthermore, patents have a limited lifespan. In the **United States-U. S.**, if all

maintenance fees are timely paid, the natural expiration of a patent is generally 20 years from its earliest U. S. non- provisional filing date. Various extensions may be available; however, the life of a patent, and the protection it affords, is limited. Even if patents covering our product candidates are obtained, once the patent life has expired for a product candidate, we may be open to competition. Given the amount of time required for the development, testing and regulatory review of new product candidates, any patents that we may obtain in the future protecting such candidates might expire before or shortly after commercialization of such candidates, if any. As a result, our owned and licensed patent portfolio may not provide us with sufficient rights to exclude others from commercializing product candidates similar or identical to ours. Even if they are unchallenged, our pending patent applications, if issued, may not provide us with any meaningful protection or prevent competitors or other third parties from designing around our patent claims to circumvent any patents that may issue by developing similar or alternative technologies or therapeutics in a non- infringing manner. For example, a third party may develop a competitive therapy that provides benefits similar to one or more of our product candidates but that uses a formulation and / or a device that falls outside the scope of our patent claims. If any patent protection that we may obtain in the future from the patent applications we hold or pursue with respect to our product candidates is not sufficiently broad to impede such competition, our ability to successfully commercialize our product candidates could be negatively affected, which would harm our business. Similar risks apply to patents or patent applications that we have in- licensed or may in the future in- license. Patent positions of life sciences companies can be uncertain and involve complex factual and legal questions and are subject of much litigation. No consistent policy governing the scope of claims allowable in the field of antibodies has emerged in the ~~United States U. S.~~ **United States U. S.** The scope of patent protection in jurisdictions outside of the ~~United States U. S.~~ **United States U. S.** is also uncertain. Changes in either the patent laws or in their interpretation in any jurisdiction that we seek patent protection may diminish our ability to protect our inventions, obtain, maintain, protect and enforce our intellectual property and other proprietary rights; and, more generally, may affect the value of our intellectual property, including the narrowing of the scope of any patents that we may obtain in the future and any that we may license. The patent prosecution process is complex, expensive, time- consuming and inconsistent across jurisdictions. We may not be able to file, prosecute, maintain, enforce, or license all necessary or desirable patent rights at a commercially reasonable cost or in a timely manner. In addition, we do not intend to pursue, and may not obtain, patent protection in all potentially relevant markets. It is possible that we will fail to identify important patentable aspects of our research and development efforts in time to obtain appropriate or any patent protection or fail to file patent applications covering inventions made in the course of development and commercialization activities before a competitor or another third party files a patent application covering, or publishes information disclosing, a similar, independently- developed invention. Such competitor' s or other third party' s patent application may pose obstacles to our ability to obtain patent protection or limit the scope of the patent protection we may obtain. While we enter into non- disclosure and confidentiality agreements with parties who have access to confidential or patentable aspects of our research and development efforts, including for example, our employees, corporate collaborators, external academic scientific collaborators, CROs, contract manufacturers, consultants, advisors and other third parties, any of these parties may breach the agreements and disclose such output before a patent application is filed, thereby endangering our ability to seek patent protection. In addition, publications of discoveries in the scientific and scholarly literature often lag behind the actual discoveries, and patent applications in the ~~United States U. S.~~ **United States U. S.** and other jurisdictions are typically not published until 18 months after filing, or in some cases not at all. Consequently, we cannot be certain that we or our licensors were the first to make the inventions claimed in our owned or in- licensed patent rights and patent applications or were the first to file for patent protection on the inventions claimed in our pending patent applications. The issuance, scope, validity, enforceability and commercial value of our and our current or future licensors' patent rights are highly uncertain. Our and our licensors' pending and future patent applications may not result in patents being issued that protect our technology or product candidates, in whole or in part, or which effectively exclude others from commercializing competitive technologies and product candidates. Further, the scope of the invention claimed in a patent application can be significantly reduced before the patent is issued, and this scope can be reinterpreted after issuance. Even where patent applications we currently own or that we license now or in the future issue as patents, they may not issue in a form that will provide us with adequate protection to prevent competitors or other third parties from competing with us, or otherwise provide us with a competitive advantage. Any patents that eventually issue may be challenged, narrowed or invalidated by third parties. Consequently, we do not know whether any of our product candidates will be protectable or remain protected by valid and enforceable patent rights. Our competitors or other third parties may be able to evade or circumvent our patent rights by developing new alternative technologies or products in a non- infringing manner. The issuance or grant of a patent is not conclusive as to its inventorship, scope, validity or enforceability, and ~~our~~ **our** patents we may obtain in the future may be challenged, invalidated, narrowed or held to be unenforceable, including in the courts or patent offices in the ~~United States U. S.~~ **United States U. S.** and abroad, or circumvented. There may be prior art of which we are not aware that may affect the validity or enforceability of a patent claim. There also may be prior art of which we are aware, but which we do not believe affects the validity or enforceability of a claim, but which may, nonetheless, ultimately be found to affect the validity or enforceability of a claim. We may become subject to a third ~~party~~ **party** pre- issuance submission of prior art or opposition, derivation, revocation, re- examination, post- grant and inter partes review, or interference proceeding and other similar proceedings challenging any patent rights we may obtain in the future or the patent rights of others, including based on priority of invention or other features of patentability, in the U. S. Patent and Trademark Office (USPTO) or other foreign patent office. An unfavorable determination in any such submission, proceeding or litigation could reduce the scope of, or invalidate, any patent rights we may obtain in the future, allow third parties to use or commercialize our technology or product candidates and compete directly with us, without payment to us (as they can now), or extinguish our ability to manufacture or commercialize product candidates without infringing third ~~party~~ **party** patent rights. Such proceedings also may result in substantial cost and require significant time from our scientists and management, even if the eventual outcome is favorable to us. In addition, there could be public announcements of

the results of hearings, motions or other interim proceedings or developments. If securities analysts or investors perceive these results to be negative, it could have a material adverse effect on the price of our common stock. In addition, given the amount of time required for the development, testing and regulatory review of new product candidates, any patents we may obtain in the future protecting such candidates might expire before or shortly after commercialization of such candidates, if any. As a result, our intellectual property may never provide us with sufficient rights to exclude others from commercializing products similar or identical to ours. Moreover, any patents or patent applications that we may own or in- license in the future may be co- owned with third parties. If we are unable to obtain an exclusive license to any such third -party co- owners' interest in any such patents or patent applications, such co- owners may be able to license their rights to other third parties, including our competitors, thereby enabling our competitors to market competing products and technology. In addition, we or our licensors may need the cooperation of any such co- owners of any patents that we may own or in- license in the future in order to enforce such patents against third parties, and such cooperation may not be provided to us or our licensors. Any of the foregoing could have a material adverse effect on our competitive position, business, financial conditions, results of operations and prospects. We could be unsuccessful in obtaining meaningful patent protection on one or more components of our platform technology. We believe that an important factor in our competitive position is our screening technology platform to identify future product candidates and therapeutic targets. Our screening platform is based in part on technology processes that are (or will be) publicly disclosed in patent applications owned by or licensed to us and we do not currently own or in- license any issued patents that protect our screening platform. Even if these patents issue from these patent applications and provide broad protection, it may be difficult or impossible to detect whether a competitor is practicing the proprietary methods claimed in such patent applications in order to discover their own product candidates and therapeutic targets. In such case, any patents that may issue from patent applications owned by or licensed to us would not provide us protection to prevent such activity. Additionally, a competitor may also practice such methods in a jurisdiction where we have no relevant patent protection. Our competitive position could be weakened by competitors or other third parties practicing the methods claimed in these patent applications in a manner we do not detect or in jurisdictions in which we or our licensors do not obtain any relevant patent protection. If we fail to comply with any of our obligations under existing or future agreements pursuant to which we license intellectual property rights or technology, if the licenses are terminated or if disputes regarding these licenses arise, we could lose significant rights or technology that are material to our business and could interfere with our ability to operate our business. We are a party to technology licenses, including in- license agreements with BWH and ~~Provincial Health Services Authority (or "PHSA")~~, and we may enter into additional licenses in the future. Such licenses do, and may in the future, impose commercial, contingent payment, royalty, insurance, indemnification, and other obligations on us. If we fail to comply with these obligations, our licensors may have the right to terminate the license, in which event we could lose valuable rights under our collaboration agreements and our ability to develop product candidates could be impaired. Additionally, should any such license agreement be terminated for any reason, there may be a limited number of replacement licensors, and a significant amount of time may be required to transition to a replacement licensor. Our rights to develop and commercialize our product candidates are subject in part to the terms and conditions of third -party licenses, pursuant to which we have acquired rights from the applicable licensors. Our rights with respect to such intellectual property may terminate, in whole or in part, if we fail to meet applicable requirements or milestones relating to development and commercialization. We may also lose our rights to develop and commercialize our product candidates under such agreements if we fail to pay required milestones or royalties. In the event of an early termination of our license agreements, all rights licensed and developed by us under these agreements may be extinguished, which may have an adverse effect on our business, financial condition, results of operations and prospects. We rely on certain of our licensors to prepare, file and prosecute patent applications and maintain patents and otherwise protect the intellectual property we license from them and may continue to do so in the future. We have limited or no control over these activities or any other intellectual property that may be related to our in- licensed intellectual property. For example, we cannot be certain that such activities by these licensors have been or will be conducted in compliance with applicable laws and regulations or will result in valid and enforceable patents and other intellectual property rights. We have limited or no control over the manner in which our licensors initiate an infringement proceeding against a third -party infringer of the intellectual property rights, or defend certain of the intellectual property that is licensed to us. It is possible that any licensors' infringement proceeding or defense activities may be less vigorous than had we conducted them ourselves. These agreements may be complex, and certain provisions in such agreements may be susceptible to multiple interpretations. The resolution of any contract interpretation disagreement that may arise could narrow what we believe to be the scope of our rights to the relevant intellectual property or technology, or increase what we believe to be our financial or other obligations under the relevant agreement, either of which could have a material adverse effect on our business, financial condition, results of operations and prospects. In addition, a third party may in the future bring claims that our performance under our license agreements, including our sponsoring of clinical trials, interferes with such third party' s rights under its agreement with one of our licensors. If any such claim were successful, it may adversely affect our rights and ability to advance our product candidates as clinical candidates or subject us to liability for monetary damages, any of which would have an adverse effect on our business, financial condition, results of operations and prospects. We are currently, and expect in the future to be, party to material license or collaboration agreements. These agreements typically impose numerous obligations and restrictions on us, such as various diligence, commercialization, insurance and payment obligations, among others, in order to maintain such licenses. Any of these restrictions or obligations could delay or otherwise negatively impact a transaction that we may wish to enter into. In addition, any termination of these licenses could result in the loss of significant rights and could harm our ability to commercialize our product candidates. Licensing of intellectual property is of high importance to our business and involves complex legal, business and scientific issues. Disputes may also arise between us and our licensors regarding intellectual property subject to a license **or collaboration** agreement, including: • the scope of rights granted under the license **or collaboration** agreement and other

interpretation- related issues; • whether, and the extent to which, our product candidates, technology and processes infringe on intellectual property of the licensor that is not subject to the licensing **or collaboration** agreement; • our right to sublicense patent and other intellectual property rights to third parties under collaborative development relationships; • the calculation and existence of certain payment obligations under the license **or collaboration** agreement; • our diligence obligations with respect to the use of the licensed technology in relation to our development and commercialization of our product candidates, and what activities satisfy those diligence obligations; • the inventorship and ownership of inventions, know- how and other intellectual property and proprietary rights resulting from the joint creation or use of intellectual property by our licensors and us and our partners; and • the priority of invention of patented technology. If disputes over intellectual property that we have licensed prevent or impair our ability to maintain our current licensing arrangements on acceptable terms, we may be unable to successfully develop and commercialize the affected product candidates. We are generally also subject to all of the same risks with respect to protection of intellectual property that we license, as we are for intellectual property that we own, which we describe below, and our success will depend in part on the ability of our licensors to adequately obtain, maintain, protect and enforce patent protection for our licensed intellectual property, especially with respect to patent rights which we exclusively in- license. If we or our licensors fail to adequately protect this intellectual property, our ability to commercialize products could suffer. We rely on certain of our licensors to prepare, file and prosecute patent applications and maintain patents and otherwise protect the intellectual property we license from them and may continue to do so in the future. We have limited control over these activities or any other intellectual property that may be related to our in- licensed intellectual property. For example, we cannot be certain that such activities by these licensors have been or will be conducted in compliance with applicable laws and regulations or will result in valid and enforceable patents and other intellectual property rights. We have limited control over the manner in which our licensors initiate an infringement proceeding against a third- party infringer of the intellectual property rights, or defend certain of the intellectual property that is licensed to us. It is possible that any licensors' infringement proceeding or defense activities may be less vigorous than had we conducted them ourselves or may not be conducted in accordance with our best interests. Furthermore, certain of our licenses may not provide us with exclusive rights to use the licensed intellectual property and technology, or may not provide us with exclusive rights to use such intellectual property and technology in all relevant fields of use and in all territories in which we may wish to develop or commercialize our technology and product candidates in the future. For example, a portion of our intellectual property portfolio is non- exclusively licensed to us and may be used by our licensors or licensed to third parties, and such third parties may have certain enforcement rights with respect to such intellectual property. Thus, patent rights licensed to us could be put at risk of being invalidated or interpreted narrowly in litigation filed by or against our licensors or another licensee or in administrative proceedings brought by or against our licensors or another licensee in response to such litigation or for other reasons. As a result, we may not be able to prevent competitors or other third parties from developing and commercializing competitive products, including in territories covered by our licenses. Our proprietary position may depend upon patents that are manufacturing, formulation or method- of- use patents, which may not prevent a competitor or other third party from using the same product candidate for another use. Composition- of- matter patents are generally considered to be the strongest form of intellectual property protection for drug products because such patents provide protection without regard to any particular method of use or manufacture or formulation of the **API-active pharmaceutical ingredient** used. We currently have a limited number of issued patents, but our pending owned U. S. and international patent applications include claims that cover compositions of matter and methods of use of our product candidates. We cannot be certain that claims in any patent that may issue from our pending owned or in- licensed patent applications will cover the composition- of- matter of any of our current or future product candidates. If we are unsuccessful in obtaining issued patents that cover the composition of matter of any of our current or future product candidates, competitors may be able to erode or negate any competitive advantage we may have and our business, financial condition, results of operations and prospects could be materially harmed. If our efforts to protect the proprietary nature of the intellectual property related to our technologies are not adequate, we may not be able to compete effectively in our market. Biotechnology and pharmaceutical companies generally, and we in particular, compete in a crowded competitive space characterized by rapidly evolving technologies and aggressive defense of intellectual property. The USPTO and various foreign governmental patent agencies require compliance with a number of procedural, documentary, fee payment and other provisions during the patent process. There are situations in which noncompliance can result in abandonment or lapse of a patent or patent application, resulting in partial or complete loss of patent rights in the relevant jurisdiction. In such an event, competitors might be able to enter the market earlier than would otherwise have been the case. We rely upon a combination of patent rights, confidentiality agreements, trade secret protection and license agreements to protect the intellectual property related to our technologies. Any disclosure to or misappropriation by third parties of our confidential proprietary information could enable competitors or other third parties to quickly duplicate or surpass our technological achievements, thus eroding our competitive position in our market. We, or any partners, collaborators, licensees or licensors may fail to identify patentable aspects of inventions made in the course of development and commercialization activities before it is too late to obtain patent protection on them. Therefore, we may miss potential opportunities to strengthen our patent position. It is possible that defects of form in the preparation or filing of our patent applications may exist, or may arise in the future, for example with respect to proper priority claims, inventorship, claim scope, or requests for patent term adjustments. If we or any partners, collaborators, licensees or licensors fail to establish, maintain or protect such patent rights and other intellectual property rights, such rights may be reduced or eliminated. If any partners, collaborators, licensees or licensors are not fully cooperative or disagree with us as to the prosecution, maintenance or enforcement of any patent rights, such patent rights could be compromised. If there are material defects in the form, preparation, prosecution, or enforcement of our patent applications, any patents that may issue from such patent applications may be invalid and / or unenforceable, and such applications may never result in valid, enforceable patents. Any of these outcomes could impair our ability to prevent competition from third parties, which may have an adverse impact on our business, financial

condition, results of operations and prospects. Currently, our patent applications are directed to our TCR- T therapy-candidates and accompanying technologies. We seek or plan to seek patent protection for our proprietary platform and product candidates by filing and prosecuting patent applications in the United States-U. S. and other countries as appropriate. Our patent portfolio also includes patent families exclusively licensed from BWB, which include pending U. S. and foreign non-provisional patent applications. Any patents that may issue from any non-provisional patent applications claiming priority to these provisional patent applications would be expected to expire on various dates from 2038 through 2043, in each case without taking into account any possible patent term adjustments or extensions. We anticipate additional patent applications will be filed both in the United States-U. S. and in other countries, as appropriate. However, we cannot predict: • whether and when any patents will issue; • the degree and range of protection that any patents that may issue will afford us against competitors; • whether any of our intellectual property will provide any competitive advantage; • whether any patents that may issue may be challenged, invalidated, modified, revoked, circumvented or found to be unenforceable; • whether or not others will obtain patents claiming inventions similar to those covered by our patent applications; or • whether we will need to initiate or defend litigation or administrative proceedings, which may be costly regardless of whether we win or lose. Additionally, we cannot be certain that the claims in our pending patent applications covering the composition of matter of our product candidates will be considered patentable by the USPTO or patent offices in foreign countries. Method-of-use patents protect the use of a product for the specified method. If we obtain any of these types of patents, they would not prevent a competitor from making and marketing a product that is identical to one of our product candidates for an indication that is outside the scope of the patented method. Moreover, even if competitors do not actively promote their product for our targeted indications, physicians may prescribe these products “ off-label. ” Although off-label prescriptions may induce or contribute to the infringement of method-of-use patents, the practice is common, and such infringement is difficult to prevent or prosecute. The strength of patents in the biotechnology and pharmaceutical field involves complex legal and scientific questions and can be uncertain. The patent applications that we own or in-license may fail to result in issued patents with claims that cover our product candidates or uses thereof in the United States-U. S. or in other foreign countries. Even if the patents do successfully issue, third parties may challenge the validity, enforceability or scope thereof, which may result in such patents being narrowed, invalidated or held unenforceable. If the breadth or strength of protection provided by the patent applications we hold with respect to our product candidates is threatened, it could dissuade companies from collaborating with us to develop, and threaten our ability to commercialize, our product candidates. Further, if we encounter delays in our clinical trials, the period of time during which we could market our product candidates under patent protection would be reduced. Since patent applications in the United States-U. S. and most other countries are confidential for a period of time after filing, we cannot be certain that we were the first to file any patent application related to our product candidates. Various post-grant review proceedings, such as inter partes review and post-grant review, are available for any interested third party to challenge the patentability of claims in any patents issued to us or our licensors. While these post-grant review proceedings have been used less frequently to invalidate biotech patents, they have been successful regarding other technologies, and these relatively new procedures are still changing, and those changes might affect future results. No assurance can be given that, if challenged, any patents that we or our licensors may obtain would be declared by a court to be valid or enforceable or that, even if found valid and enforceable, a competitor’s technology or product would be found by a court to infringe any such patent. We may analyze patents or patent applications of our competitors that we believe are relevant and conclude that our activities do not infringe any valid claims of those patents or patent applications, but our conclusions may be erroneous or our competitors may obtain patents with issued claims, including in patents we consider to be unrelated, that block our efforts or that our product candidates or our activities infringe. Others may independently develop products that have the same effect as our product candidates without infringing any patents we may obtain or any of our other intellectual property rights, or they may design around the claims of any patents that we may obtain. Recent and future patent reform legislation could increase the uncertainties and costs surrounding the prosecution of our patent applications and the enforcement or defense of any patents we may obtain. In March 2013, under the Leahy-Smith America Invents Act (, or the America Invents Act), the United States-U. S. moved from a “ first to invent ” to a “ first-to-file ” system. Under a “ first-to-file ” system, assuming the other requirements for patentability are met, the first inventor to file a patent application generally will be entitled to a patent on the invention regardless of whether another inventor had made the invention earlier. The America Invents Act included a number of other significant changes to U. S. patent law, including provisions that have affected the way patent applications are prosecuted, redefined prior art and established a new post-grant review system. The effects of these changes are still unclear as the USPTO only recently developed new regulations and procedures in connection with the America Invents Act, and many of the substantive changes to patent law, including the “ first-to-file ” provisions, only became effective in March 2013. Moreover, the courts have yet to address many of these provisions. Overall, the America Invents Act and its implementation have increased the uncertainties and costs surrounding the prosecution of our patent applications and any enforcement or defense of any patents that we may obtain, which could have a material adverse effect on our business and financial condition. The degree of future protection for our proprietary rights is uncertain because legal means afford only limited protection and may not adequately protect our rights or permit us to gain or keep our competitive advantage. For example: • others may be able to make or use compounds or cells that are similar to the biological compositions of our product candidates but that are not covered by the claims of any patents that we may obtain; • the active biological ingredients in our current product candidates may eventually become commercially available in biosimilar drug products, and no patent protection may be available with regard to formulation or method of use; • we or our licensors, as the case may be, might not have been the first to file patent applications for these inventions; • there may be prior public disclosures that could invalidate any patents that we or our licensors may obtain; • the inventors of our owned or in-licensed patent applications may become involved with competitors, develop products or processes that design around any patents that we may obtain, or become adverse to us or patent applications on which they are named as inventors; • it is possible that our owned or

in- licensed patent applications omit individual (s) that should be listed as inventor (s) or include individual (s) that should not be listed as inventor (s), which may cause any patents that may issue from these patent applications to be held invalid or unenforceable; • we have engaged and may continue to engage in scientific collaborations, and such collaborators may develop adjacent or competing products to ours that are outside the scope of any patents that we may obtain; • we may not develop additional proprietary technologies for which we can obtain patent protection; • product candidates or diagnostic tests we develop may be covered by third parties' patents or other exclusive rights; or • the patents of others may have an adverse effect on our business. If we are unable to protect the confidentiality of our trade secrets, our business and competitive position would be harmed. In addition to the protection afforded by any patent rights we may obtain, we seek to rely on trade secret protection, confidentiality agreements, and license agreements to protect our proprietary know- how, information, technology and other proprietary information that is not patentable, processes for which patents are difficult to enforce and any other elements of our product discovery and development processes that involve proprietary know- how, information, or technology that we have not sought to protect through patent applications. For example, significant elements of our product candidates, including aspects of sample preparation, methods of manufacturing, cell culturing conditions, computational- biological algorithms, and related processes and software, are based on unpatented trade secrets that are not publicly disclosed. It is our policy to require our employees, consultants, outside scientific collaborators, sponsored researchers and other advisors to execute confidentiality agreements upon the commencement of employment or consulting relationships with us. These agreements generally provide that all confidential information concerning our business or financial affairs developed or made known to the individual or entity during the course of the party' s relationship with us is to be kept confidential and not disclosed to third parties except in specific circumstances. In the case of employees, the agreements provide that all inventions conceived by the individual, and which are related to our current or planned business or research and development or made during normal working hours, on our premises or using our equipment or proprietary information, are our exclusive property. In addition, we take other appropriate precautions, such as physical and technological security measures, to guard against misappropriation of our proprietary technology by third parties. Despite these measures, we cannot be certain that our trade secrets and other confidential proprietary information will not be disclosed or that competitors will not otherwise gain access to our trade secrets or independently develop substantially equivalent information and techniques. Furthermore, the laws of some foreign countries do not protect proprietary rights to the same extent or in the same manner as the laws of the United States U. S. . Courts outside the United States U. S. are sometimes less willing to protect trade secrets. As a result, we may encounter significant problems in protecting and defending our intellectual property both in the United States U. S. and abroad. If we choose to go to court to stop a third party from using any of our trade secrets, we may incur substantial costs. These lawsuits may consume our time and other resources even if we are successful. If we are unable to prevent unauthorized disclosure of our material intellectual property to third parties, we will not be able to establish or maintain a competitive advantage in our market, which could materially adversely affect our business, operating results and financial condition. For more information, see " Risk Factors — Risks Related to Our Intellectual Property — " " We have limited foreign intellectual property rights and may not be able to protect our intellectual property rights throughout the world. " " Our commercial success depends in part on our avoiding infringement, misappropriation or other violation of the patents and proprietary rights of third parties. There is a substantial amount of litigation involving patents and other intellectual property rights in the biotechnology and pharmaceutical industries. We may be exposed to, or threatened with, future litigation by third parties having patent or other intellectual property rights alleging that our product candidates and / or technologies infringe their intellectual property rights. Numerous U. S. and foreign issued patents and pending patent applications, which are owned by third parties, exist in the fields in which we are developing our product candidates or identifying potential product candidates. As the biotechnology and pharmaceutical industries expand and more patents are issued, the risk increases that our product candidates may give rise to claims of infringement of the patent rights of others. Moreover, it is not always clear to industry participants, including us, which patents cover various types of drugs, products or their methods of use or manufacture. Because of the large number of patents and patent applications in our fields, there is a risk that third parties may allege they have patent rights encompassing our product candidates, technologies or methods. If a third party claims that we infringe, misappropriate or otherwise violate its intellectual property rights, we may face a number of issues, including, but not limited to: • infringement, misappropriation and other violation of intellectual property claims which, regardless of merit, may be expensive and time- consuming to litigate and may divert our management' s attention from our core business; • substantial damages for infringement, misappropriation or other violation which we may have to pay if a court decides that the product candidate or technology at issue infringes on, misappropriates or otherwise violates the third party' s rights, and, if the court finds that the infringement was willful, we could be ordered to pay treble damages and the patent owner' s attorneys' fees; • a court prohibiting us from developing, manufacturing, marketing or selling our product candidates, or from using our proprietary technologies, unless the third party licenses its product rights to us, which it is not required to do; • if a license is available from a third party, we may have to pay substantial royalties, upfront fees and other amounts, and / or grant cross- licenses to intellectual property rights for our product candidates or using our proprietary technologies; and • redesigning our product candidates or processes so they do not infringe third - party intellectual property rights, which may not be possible or may require substantial monetary expenditures and time. Some of our competitors or other third parties may be able to sustain the costs of complex patent litigation more effectively than we can because they have substantially greater resources. In addition, any uncertainties resulting from the initiation and continuation of any litigation could have a material adverse effect on our ability to raise the funds necessary to continue our operations or could otherwise have a material adverse effect on our business, results of operations, financial condition and prospects. Third parties may assert that we are employing their proprietary technology without authorization. Generally, conducting preclinical and clinical trials and other development activities in the United States U. S. is not considered an act of infringement. If any of our product candidates is licensed by the FDA, a third party may then seek to enforce its patent by filing a patent infringement lawsuit against us. While we do not

believe that any claims that could otherwise have a materially adverse effect on the commercialization of our product candidates, if licensed, are valid and enforceable, we may be incorrect in this belief, or we may not be able to prove it in litigation. In this regard, patents issued in the United States U. S. by law enjoy a presumption of validity that can be rebutted only with evidence that is “clear and convincing”, a heightened standard of proof. As a result, there is no assurance that a court of competent jurisdiction would invalidate the claims of any such U. S. patent. If any third party patent were held by a court of competent jurisdiction to cover the manufacturing process of our product candidates, constructs or molecules used in or formed during the manufacturing process, or any final product itself, or aspects of our formulations, processes for manufacture or methods of use, including combination therapy or patient selection methods, the holder of any such patent may be able to block our ability to commercialize the product candidate unless we obtained a license under the applicable patent, or until such patent expires or it is finally determined to be held invalid or unenforceable. In any case, such a license may not be available on commercially reasonable terms or at all. If we are unable to obtain a necessary license to a third party patent on commercially reasonable terms, or at all, our ability to commercialize our product candidates may be impaired or delayed, which could in turn significantly harm our business. Even if we obtain a license, it may be non-exclusive, thereby giving our competitors access to the same technologies licensed to us, and it could require us to make substantial licensing and royalty payments. In addition, there could be public announcements of the results of hearings, motions or other interim proceedings or developments. If securities analysts or investors perceive these results to be negative, it could have a material adverse effect on the price of our common stock. Any of the foregoing events could harm our business, financial condition, results of operations and prospects. Parties making claims against us may seek and obtain injunctive or other equitable relief, which could effectively block our ability to further develop and commercialize our product candidates. Defense of these claims, regardless of their merit, could involve substantial litigation expense and would be a substantial diversion of employee resources from our business. In the event of a successful claim of infringement against us, we may have to pay substantial damages, including treble damages and attorneys’ fees for willful infringement, obtain one or more licenses from third parties, pay royalties or redesign our infringing products, which may be impossible or require substantial time and monetary expenditure. We cannot predict whether any such license would be available at all or whether it would be available on commercially reasonable terms. Furthermore, even in the absence of litigation, we may need or may choose to obtain licenses from third parties to advance our research or allow commercialization of our product candidates. We may fail to obtain any of these licenses at a reasonable cost or on reasonable terms, if at all. In that event, we would be unable to further develop and commercialize our product candidates. Any of the foregoing events could harm our business, financial condition, results of operations and prospects. We may not be successful in obtaining or maintaining necessary rights to product components and processes for our development pipeline through acquisitions and in-licenses. Because additional product candidates may require the use of proprietary rights held by third parties, the growth of our business will likely depend in part on our ability to acquire, in-license or use these proprietary rights. In addition, while we have certain patent rights directed to certain TCR constructs, we may not be able to obtain intellectual property to broad T cell or TCR ~~T~~ constructs. Our product candidates may also require specific formulations to work effectively and efficiently and rights to these formulations may be held by others. Similarly, efficient production or delivery of our product candidates may also require specific compositions or methods, and the rights to these may be owned by third parties. We may be unable to acquire or in-license any formulations, compositions, methods of use, processes or other third party intellectual property rights that we identify as necessary or important to our business operations. We may fail to obtain any of these licenses at a reasonable cost or on reasonable terms, if at all, which would harm our business. We may need to cease use of the compositions or methods covered by such third party intellectual property rights, and may need to seek to develop alternative approaches that do not infringe on such intellectual property rights which may entail additional costs and development delays, even if we were able to develop such alternatives, which may not be feasible. Even if we are able to obtain a license, it may be non-exclusive, thereby giving our competitors access to the same technologies licensed to us. In that event, we may be required to expend significant time and resources to develop or license replacement technology. Moreover, the specific antibodies that will be used with our product candidates may be covered by the intellectual property rights of others. Additionally, we may collaborate with academic institutions to accelerate our preclinical research or development under written agreements with these institutions. In certain cases, these institutions provide us with an option to negotiate a license to any of the institution’s rights in technology resulting from the collaboration. Regardless of such option, we may be unable to negotiate a license within the specified timeframe or under terms that are acceptable to us. If we are unable to do so, the institution may offer the intellectual property rights to others, potentially blocking our ability to pursue our program. If we are unable to successfully obtain rights to required third party intellectual property or to maintain the existing intellectual property rights we have, we may have to abandon development of such program and our business and financial condition could suffer. The licensing and acquisition of third party intellectual property rights is a competitive area, and companies that may be more established or have greater resources than we do may also be pursuing strategies to license or acquire third party intellectual property rights that we may consider necessary or attractive in order to commercialize our product candidates. More established companies may have a competitive advantage over us due to their size, cash resources and greater clinical development and commercialization capabilities. We may eventually become involved in lawsuits to protect or enforce our intellectual property and proprietary rights, including any patents that we or our licensors may obtain in the future, which could be expensive, time-consuming and unsuccessful. In the future, competitors or other third parties may infringe any patents that we or our licensors may obtain. To counter any such future infringement or unauthorized use, we may eventually be required to file infringement claims, which can be expensive and time-consuming. Any claims we assert against perceived infringers could provoke these parties to assert counterclaims against us alleging that we infringe their patents or that our licensors’ patents are invalid or unenforceable. In addition, in a patent infringement proceeding, a court may decide that one or more patents that we may obtain in the future is not valid or is unenforceable, in whole or in part, construe the patent’s claims narrowly or may refuse to stop the

other party from using the technology at issue on the grounds that such patents, if any, do not cover the technology in question. An adverse result in any litigation or defense proceedings could put one or more of such patents, if any, at risk of being invalidated, held unenforceable, or interpreted narrowly and could put our patent applications at risk of not issuing. Asserting any patent rights we may obtain in the future, and defending challenges to our rights, regardless of their merit, would involve substantial litigation expense and would be a substantial diversion of employee resources from our business and we may find it impractical or undesirable to enforce our intellectual property against some third parties. Post- grant, interference or derivation proceedings provoked by third parties or brought by us or declared by the USPTO may be necessary to determine the validity or priority of inventions with respect to our or our licensors' patent applications or any patents that may issue therefrom. An unfavorable outcome could result in a loss of any patent rights we may have. Furthermore, because of the substantial amount of discovery required in connection with intellectual property litigation, there is a risk that some of our confidential information could be compromised by disclosure during this type of litigation or proceeding. In addition, there could be public announcements of the results of hearings, motions or other interim proceedings or developments. If securities analysts or investors perceive these results to be negative, it could have a material adverse effect on the price of our common stock. Any of the foregoing events could harm our business, financial condition, results of operations and prospects. Obtaining and maintaining our patent protection depends on compliance with various procedures, document submission, fee payments and other requirements imposed by governmental patent agencies, and our patent protection could be reduced or eliminated for non-compliance with these requirements. Some of our patent applications may be allowed in the future. We cannot be certain that an allowed patent application will become an issued patent. There may be events that cause withdrawal of the allowance of a patent application. For example, after a patent application has been allowed, but prior to being issued, material that could be relevant to patentability may be identified. In such circumstances, the applicant may pull the application from allowance in order for the USPTO or foreign patent agency to review the application in view of the new material. In that circumstance, the USPTO or the other agency may not re- allow an application in view of the new material. Further, periodic maintenance fees, renewal fees, annuity fees and various other governmental fees on patents and / or patent applications will be due to be paid to the USPTO and foreign patent agencies at several stages over the lifetime of the patents and / or patent applications. The USPTO and various foreign governmental patent agencies also require compliance with a number of procedural, documentary and other similar provisions during the patent application process and following the issuance of a patent. We also may be dependent on our licensors to take the necessary action to comply with these requirements with respect to our licensed intellectual property. While an inadvertent lapse can in many cases be cured by payment of a late fee or by other means in accordance with the applicable rules, there are situations in which noncompliance can result in abandonment or lapse of the patent or patent application, resulting in partial or complete loss of patent rights in the relevant jurisdiction. Noncompliance events that could result in abandonment or lapse of a patent or patent application include, but are not limited to, failure to respond to official actions within prescribed time limits, non- payment of fees and failure to properly legalize and submit formal documents. In such an event, our competitors and other third parties might be able to enter the market without infringing our or our licensors' patents and patent applications, which could have a material adverse effect on our business, financial condition, results of operations and prospects. If we obtain any patents covering our product candidates, they could nonetheless be found invalid or unenforceable if challenged in court or the USPTO. The issuance of a patent is not conclusive as to its inventorship, scope, validity or enforceability. Our owned or in- licensed patents, and any of our owned or in- licensed patent applications that may issue in the future, may be challenged at the USPTO or foreign patent offices in re- examination, inter partes review, post- grant review and equivalent proceedings in foreign jurisdictions (such as opposition proceedings). Such proceedings could result in the revocation of or amendment to such patents in such a way that they no longer cover our product candidates or technologies. If we or one of our licensing partners initiates legal proceedings against a third party to enforce a patent that we may obtain in the future covering one of our product candidates, the defendant could counterclaim that such patent is invalid and / or unenforceable. In patent litigation in the United States U. S., counterclaims alleging invalidity and / or unenforceability are commonplace, and there are numerous grounds upon which a third party can assert invalidity or unenforceability of a patent. Grounds for a validity challenge could be an alleged failure to meet any of several statutory requirements, including lack of novelty, obviousness or non- enablement. Grounds for an unenforceability assertion could be an allegation that someone connected with prosecution of the patent withheld relevant information from the USPTO, or made a misleading statement, during prosecution. Third parties may also raise similar claims before administrative bodies in the United States U. S. or abroad, even outside the context of litigation. Such mechanisms include re- examination, inter partes review, post- grant review and equivalent proceedings in foreign jurisdictions (such as opposition proceedings). Such proceedings could result in revocation or amendment to any patents we may obtain in the future in such a way that they would no longer cover our product candidates. The outcome following legal assertions of invalidity and unenforceability is unpredictable. With respect to the validity question, for example, we cannot be certain that there is no invalidating prior art, of which we, our patent counsel and the patent examiner were unaware during prosecution. If a defendant were to prevail on a legal assertion of invalidity and / or unenforceability, or if we are otherwise unable to adequately protect our rights, we would lose at least part, and perhaps all, of any patent protection we may eventually obtain on our product candidates and technologies. Such a loss of patent protection could have a material adverse impact on our business, financial condition, results of operations and prospects and our ability to commercialize or license our technology and product candidates. Changes to patent law and its interpretation in the United States U. S. and in foreign jurisdictions could diminish the value of patents in general and may impact the validity, scope or enforceability of our patent rights, thereby impairing our ability to protect our product candidates and technologies. As is the case with other biopharmaceutical companies, our success is heavily dependent on intellectual property, particularly any patents that may issue from our pending patent applications. Changes in either the patent laws or in their interpretation in any jurisdiction that we seek patent protection may diminish our ability to protect our inventions, obtain, maintain and enforce our intellectual property and proprietary rights and,

more generally, may affect the value of our intellectual property and proprietary rights. The ~~United States~~ **U. S.** continues to adapt to wide-ranging patent reform legislation that became effective starting in 2012. Moreover, various courts, including the U. S. Supreme Court, have rendered decisions that have narrowed the scope of patent protection available in certain circumstances and weakened the rights of patent owners in certain situations. In addition to increasing uncertainty with regard to our ability to obtain patents in the future, this combination of events has created uncertainty with respect to the value of patents once obtained. Depending on decisions by ~~the U. S.~~ Congress, the federal courts, and the USPTO, the laws and regulations governing patents could change in unpredictable ways that would weaken our ability to obtain new patents or to enforce patents that we might obtain in the future. For example, in the case *Assoc. for Molecular Pathology v. Myriad Genetics, Inc.*, the U. S. Supreme Court held that certain claims to DNA molecules are not patentable. We cannot predict how future decisions by the courts, Congress or the USPTO may impact the value of our pending patent applications. Similarly, any adverse changes in the laws and regulations governing patents in other jurisdictions could have an adverse effect on our ability to obtain and effectively enforce our patent rights and have a material adverse effect on our business and financial condition. Filing, prosecuting and defending patents on product candidates in all countries throughout the world would be prohibitively expensive, and our intellectual property rights in some countries outside the ~~United States~~ **U. S.** can be less extensive than those in the ~~United States~~ **U. S.** In addition, the laws of some foreign countries do not protect intellectual property rights to the same extent as the laws in the ~~United States~~ **U. S.**, and we may encounter difficulties in protecting and defending such rights in foreign jurisdictions. Consequently, we may not be able to prevent third parties from practicing our inventions in some or all countries outside the ~~United States~~ **U. S.**, or from selling or importing products made using our inventions in and into the ~~United States~~ **U. S.** or other jurisdictions. Competitors or other third parties may use our technologies in jurisdictions where we have not obtained patent protection to develop their own products and further, may also export otherwise infringing products to territories where we have patent protection, but enforcement is not as strong as in the ~~United States~~ **U. S.** These products may compete with our product candidates and our patent rights or other intellectual property rights may not be effective or sufficient to prevent them from competing. In addition, certain countries have compulsory licensing laws under which a patent owner may be compelled to grant licenses to other parties. Furthermore, many countries limit the enforceability of patents against other parties, including government agencies or government contractors. In these countries, the patent owner may have limited remedies, which could materially diminish the value of any patents. Most of our patent portfolio is at ~~the a~~ very early stage. We will need to decide whether, and in which jurisdictions, to pursue protection for the various inventions in our portfolio prior to applicable filing deadlines. Many companies have encountered significant problems in protecting and defending intellectual property rights in foreign jurisdictions. The legal systems of certain countries, particularly certain developing countries, do not favor the enforcement of patents, trade secrets and other intellectual property protection, particularly those relating to biopharmaceutical products and biotechnology, which could make it difficult for us to stop the infringement, misappropriation or other violation of our intellectual property rights, including any infringement of any patents we may obtain in the future in such countries, or marketing of competing products in violation of our proprietary rights generally. Proceedings to enforce any patent rights we may obtain in the future in foreign jurisdictions could result in substantial costs and divert our efforts and attention from other aspects of our business, could put our patent applications at risk of not issuing, any patents we obtain in the future at risk of being invalidated or interpreted narrowly and could provoke third parties to assert claims against us. We may not prevail in any lawsuits that we initiate, and the damages or other remedies awarded, if any, may not be commercially meaningful. Accordingly, our efforts to establish our intellectual property rights around the world may be inadequate to obtain a significant commercial advantage from the intellectual property that we develop or license. We may be subject to claims challenging the inventorship or ownership of our patent rights and other intellectual property. We may be subject to claims that former employees, collaborators or other third parties have an interest in our intellectual property as an inventor or co-inventor. It is our policy to enter into confidentiality and intellectual property assignment agreements with our employees, consultants, and contractors. These agreements generally provide that inventions conceived by the party in the course of rendering services to us will be our exclusive property. However, such agreements may not be honored and may not effectively assign intellectual property rights to us. For instance, the assignment of intellectual property rights may not be self-executing, or the assignment agreements may be breached, and we may be forced to bring claims against current or former employees, consultants, and contractors, or defend claims that they may bring against us, to determine the ownership of what we regard as our intellectual property. Moreover, there may be circumstances where we are unable to negotiate for such ownership rights. Disputes regarding ownership or inventorship of intellectual property can also arise in other contexts, such as collaborations and sponsored research. If we are subject to a dispute challenging our rights in or to inventions or other intellectual property, such a dispute could be expensive and time consuming. If we are unsuccessful in defending such claims, in addition to paying monetary damages, unless we are able to obtain a license, which might not be available on commercially reasonable terms or at all, we could lose valuable rights in intellectual property, such as the exclusive ownership of, or right to use, intellectual property that we regard as our own or that is important to our business. Even if we are successful in defending against such claims, litigation could result in substantial costs and be a distraction to management and other employees, and certain customers, licensors or partners may defer engaging with us until the particular dispute is resolved. Any of the foregoing could have a material adverse effect on our business, financial condition, results of operations and prospects. We may be subject to claims that our employees, consultants or independent contractors have wrongfully used or disclosed trade secrets or other confidential information of their former employers or other third parties or claims asserting ownership of what we regard as our own intellectual property. We have received, and will continue to receive, confidential and proprietary information from third parties. In addition, we have employed and expect to continue to employ individuals who were previously employed at university or other biotechnology or pharmaceutical companies, including our competitors or potential competitors, in some cases until recently. Although we try to ensure that our employees, consultants, advisors and independent contractors do not use the proprietary information or know-

how of others in their work for us, we may be subject to claims that we, our employees, advisors, consultants or independent contractors have deliberately, inadvertently or otherwise used or disclosed intellectual property, including trade secrets or other proprietary information of these former employers, competitors or other third parties, or to claims that we have improperly used or obtained such trade secrets. We may be subject to claims that we or our employees, consultants or independent contractors have inadvertently or otherwise used or disclosed confidential information of these third parties or our employees' former employers or our consultants' or contractors' current or former clients or customers. Litigation may be necessary to defend against these claims. Even if we are successful in defending against these claims, litigation could result in substantial ~~cost~~ **costs** and be a distraction to our management and employees. If we are not successful in defending such claims, in addition to paying monetary damages, we could lose access or exclusive access to valuable intellectual property rights and face increased competition to our business. Any of the foregoing could harm our business, financial condition, results of operations and prospects. We may be subject to claims, and damages resulting from claims, that we or our employees have wrongfully used or disclosed alleged trade secrets of our competitors or are in breach of non- competition or non- solicitation agreements with our competitors. Many of our employees were previously employed at other pharmaceutical companies, including our competitors or potential competitors, in some cases until recently. We may be subject to claims that we or our employees have inadvertently or otherwise used or disclosed trade secrets or other proprietary information **of belonging to** these former employers or competitors. In addition, we have been and may in the future be subject to claims that we caused an employee to breach the terms of his or her non- competition or non- solicitation agreement. Litigation may be necessary to defend against these claims. Even if we are successful in defending against these claims, litigation could result in substantial costs and could be a distraction to management. If our defense to those claims fails, in addition to paying monetary damages, we may lose valuable intellectual property rights or personnel. Any litigation or the threat thereof may adversely affect our ability to hire employees. A loss of key personnel or their work product could hamper or prevent our ability to commercialize product candidates or potential products, which could have an adverse effect on our business, results of operations, financial condition and prospects. Patent terms may be inadequate to protect our competitive position on our product candidates for an adequate amount of time. If we do not obtain patent term extension and data exclusivity for any of our current or future product candidates, our business may be materially harmed. Depending upon the timing, duration, conditions and specifics of any FDA marketing approval of any of our current or future product candidates that we may receive, one or more U. S. patents that we may obtain in the future may be eligible for limited patent term extension under the Drug Price Competition and Patent Term Restoration Act of 1984 ~~(, or the Hatch-Waxman Amendments)~~ and one or more of our foreign patent rights may be eligible for patent term extension under similar legislation, for example, in the ~~EU European Union~~ **EU** ~~United States~~ **U.S.**, the Hatch- Waxman Amendments permit a patent extension term of up to five years as compensation for effective patent term lost during product development and the FDA regulatory review process. A patent term extension cannot extend the remaining term of a patent beyond a total of 14 years from the date of product approval, only one patent may be extended and only those claims covering the approved drug, a method for using it, or a method for manufacturing it may be extended. However, there are no assurances that the FDA or any comparable foreign regulatory authority or national patent office will grant such extensions, in whole or in part. For example, we may not be granted an extension if we fail to exercise due diligence during the testing phase or regulatory review process, fail to apply within applicable deadlines, fail to apply prior to the expiration of relevant patents, or otherwise fail to satisfy other applicable requirements. Moreover, the applicable time period or the scope of patent protection afforded could be less than we request. If we are unable to obtain patent term extension or term of any such extension is less than we request, the period during which we can enforce our patent rights for the applicable product candidate will be shortened, and our competitors or other third parties may obtain approval to market competing products following expiration of any patents that we may obtain in the future, and our business, financial condition, results of operations, and prospects could be materially harmed. If our trademarks are not adequately protected, then we may not be able to build name recognition in our markets of interest and our business may be adversely affected. We rely on both registered and common law protection for our trademarks ~~, and have filed applications to register various trademarks, including "TSCAN THERAPEUTICS" and "TSCAN,"~~ **and have filed applications to register various trademarks, including "TSCAN THERAPEUTICS" and "TSCAN,"** for use in connection with our product candidates and services in various countries. These trademarks may not afford adequate protection. Our trademark applications may be provisionally or ultimately refused by the USPTO or the trademark agencies of other countries, or such applications may be challenged by others. We also may not have the financial resources to enforce the rights under these trademarks, which may enable others to use the trademarks and dilute their value. Our trademarks may be challenged, infringed, circumvented or declared generic or determined to be infringing the trademarks of others. In such a case, we may not be able to protect or derive any value from such trademarks ~~, or may be required to cease using a conflicting mark entirely.~~ The value of our trademarks may also be diminished by our own actions, such as failing to impose appropriate quality control when licensing our trademarks. Any of the foregoing could impair the value of, or ability to use, our trademarks, reduce our ability to compete effectively, and have an adverse effect on our business. Certain of our in- licensed patent rights are, and our future owned and in- licensed patent rights may be, subject to a reservation of rights by one or more third parties, including government march- in rights with regards to certain patents, that may limit our ability to exclude third parties from commercializing product candidates similar or identical to ours. Certain of our in- licensed patent rights may be subject to a reservation of rights by one or more third parties. Pursuant to the Bayh- Dole Act, the U. S. government has march- in rights with regards to government- funded technology. For example, the U. S. government has certain rights, including march- in rights, to patent rights and technology funded by the U. S. government and licensed to us from BWH. When new technologies are developed with government funding, in order to secure ownership of such patent rights, the recipient of such funding is required to comply with certain government regulations, including timely disclosing the inventions claimed in such patent rights to the U. S. government and timely electing title to such inventions. Any failure to timely elect title to such inventions may provide the U. S. government with the right to, at any time, take title to such inventions. Additionally, the U. S. government generally obtains certain rights in any resulting patents, including a non-

exclusive license authorizing the government to use the invention or to have others use the invention on its behalf. If the government decides to exercise these rights, it is not required to engage us as its contractor in connection with doing so. These rights may permit the U. S. government to disclose our confidential information to third parties and to exercise march-in rights to use or allow third parties to use our licensed technology. The U. S. government can exercise its march-in rights if it determines that action is necessary because we fail to achieve practical application of the government-funded technology, because action is necessary to alleviate health or safety needs, to meet requirements of federal regulations, or to give preference to U. S. industry. In addition, our rights in such inventions may be subject to certain requirements to manufacture products embodying such inventions in the United States **U. S.** Any exercise by the government of any of the foregoing rights could harm our competitive position, business, financial condition, results of operations, and prospects. ~~We plan to rely on third parties to conduct our clinical trials. If these third parties do not properly and successfully carry out their contractual duties or meet expected deadlines, we may not be able to obtain regulatory approval of or commercialize our product candidates.~~ We plan to utilize and depend upon independent investigators and collaborators, such as medical institutions, CROs, CMOs and strategic partners to conduct our preclinical studies and clinical trials under agreements with us. We expect to have to negotiate budgets and contracts with CROs, trial sites and CMOs which may result in delays to our development timelines and increased costs. We will rely heavily on these third parties over the course of our clinical trials, and we control only certain aspects of their activities. As a result, we will have less direct control over the conduct, timing and completion of these clinical trials and the management of data developed through clinical trials than would be the case if we were relying entirely upon our own staff. Nevertheless, we are responsible for ensuring that each of our studies is conducted in accordance with applicable protocol, legal and regulatory requirements and scientific standards, and our reliance on third parties does not relieve us of our regulatory responsibilities. We and these third parties are required to comply with GCPs, which are regulations and guidelines enforced by the FDA and comparable foreign regulatory authorities for product candidates in clinical development. Regulatory authorities enforce these GCPs through periodic inspections of trial sponsors, principal investigators and trial sites. If we or any of these third parties fail to comply with applicable GCP regulations, the clinical data generated in our clinical trials may be deemed unreliable and the FDA or comparable foreign regulatory authorities may require us to perform additional clinical trials before approving our marketing applications. We cannot provide assurance that, upon inspection, such regulatory authorities will determine that any of our clinical trials comply with the GCP regulations. In addition, our clinical trials must be conducted with biologic product produced under cGMP regulations, including cGTP regulations, and will require a large number of test patients. Our failure or any failure by these third parties to comply with these regulations or to recruit a sufficient number of patients may require us to repeat clinical trials, which would delay the regulatory approval process. Moreover, our business may be implicated if any of these third parties violates federal or state fraud and abuse or false claims laws and regulations or healthcare privacy and security laws. Any third parties conducting our clinical trials are not and will not be our employees and, except for remedies available to us under our agreements with such third parties, we cannot control whether or not they devote sufficient time and resources to our ongoing, clinical and non-clinical product candidates. These third parties may also have relationships with other commercial entities, including our competitors, for whom they may also be conducting clinical trials or other drug development activities, which could affect their performance on our behalf. If these third parties do not successfully carry out their contractual duties or obligations or meet expected deadlines, if they need to be replaced or if the quality or accuracy of the clinical data they obtain is compromised due to the failure to adhere to our clinical protocols or regulatory requirements or for other reasons, our clinical trials may be extended, delayed or terminated and we may not be able to complete development of, obtain regulatory approval of or successfully commercialize our product candidates. As a result, our financial results and the commercial prospects for our product candidates would be harmed, our costs could increase and our ability to generate revenue could be delayed. Switching or adding third parties to conduct our clinical trials involves substantial cost and requires extensive management time and focus. In addition, there is a natural transition period when a new third party commences work. As a result, delays occur, which can materially impact our ability to meet our desired clinical development timelines. We have in the past and may in the future form or seek collaborations or strategic alliances or enter into additional licensing arrangements in the future, and we may not realize the benefits of such collaborations, alliances or licensing arrangements. We have in the past and may in the future form or seek strategic alliances, create joint ventures or collaborations, or enter into additional licensing arrangements with third parties that we believe will complement or augment our development and commercialization efforts with respect to our product candidates and any future product candidates that we may develop. Any of these relationships may require us to incur non-recurring and other charges, increase our near and long-term expenditures, issue securities that dilute our existing stockholders or disrupt our management and business. In addition, we face significant competition in seeking appropriate strategic partners and the negotiation process is time-consuming and complex. Moreover, we may not be successful in our efforts to establish a strategic partnership or other alternative arrangements for our product candidates because they may be deemed to be at too early of a stage of development for collaborative effort and third parties may not view our product candidates as having the requisite potential to demonstrate safety, potency and purity and obtain marketing approval. Further, collaborations involving our product candidates are subject to numerous risks, which may include the following: • collaborators have significant discretion in determining the efforts and resources that they will apply to a collaboration; • collaborators may not perform their obligations as expected; • collaborators may not pursue development and commercialization of our product candidates or may elect not to continue or renew development or commercialization of our product candidates based on clinical trial results, changes in their strategic focus due to the acquisition of competitive products, availability of funding or other external factors, such as a business combination that diverts resources or creates competing priorities; • collaborators may delay clinical trials, provide insufficient funding for a clinical trial, stop a clinical trial, abandon a product candidate, repeat or conduct new clinical trials or require a new formulation of a product candidate for clinical testing; • collaborators could independently develop, or develop with third parties, products that compete directly or indirectly with our product candidates; • a collaborator

with marketing and distribution rights to one or more products may not commit sufficient resources to their marketing and distribution; • collaborators may not properly maintain or defend our intellectual property or proprietary rights or may use our intellectual property or proprietary information in a way that gives rise to actual or threatened litigation that could jeopardize or invalidate our intellectual property or proprietary information or expose us to potential liability; • disputes may arise between us and a collaborator that cause the delay or termination of the research, development or commercialization of our product candidates, or that result in costly litigation or arbitration that diverts management attention and resources; • the number and type of our collaborations could adversely affect our attractiveness to future collaborators or acquirers; • there may be conflicts between different collaborators that could negatively affect those collaborations and potentially others; • collaborations may be terminated and, if terminated, may result in a need for additional capital to pursue further development or commercialization of the applicable product candidates; and • collaborators may own or co-own intellectual property covering our product candidates that results from our collaborating with them, and in such cases, we would not have the exclusive right to commercialize such intellectual property. As a result, if we enter into additional collaboration agreements and strategic partnerships or license our product candidates, we may not be able to realize the benefit of such transactions if we are unable to successfully integrate them with our existing operations and company culture, which could delay our timelines or otherwise adversely affect our business. We also cannot be certain that, following a strategic transaction or license, we will achieve the revenue or specific net income that justifies such transaction. Any delays in entering into new collaborations or strategic partnership agreements related to our product candidates could delay the development and commercialization of our product candidates in certain geographies for certain indications, which would harm our business prospects, financial condition and results of operations. Our collaboration agreements may grant our collaborators exclusive rights under certain of our intellectual property and may therefore preclude us from entering into collaborations with others relating to the same or similar compounds, therapeutic targets, indications or diseases. **Our Amgen** For example, our existing Collaboration and License Agreement, to identify antigens recognized by T cells in patients with Novartis Institutes-Crohn's disease, grants Amgen options to evaluate a variety of modalities to create therapeutics based on targets discovered by us, and Amgen will retain all global development and commercialization rights. Amgen may terminate the Amgen Agreement in its entirety for BioMedical Research, Inc. (Novartis) grants Novartis options to obtain exclusive, worldwide licenses to certain target antigens identified in performance of such agreement and corresponding T cell receptors for such target antigens. In addition, our collaboration agreements may place restrictions or our additional obligations on **insolvency, uncured material breach, our or failure ability to license additional compounds in different indications, targets, diseases or geographical locations. If we fail to comply with specified compliance or breach any provision provisions or subject** of a collaboration agreement, a collaborator may have the right to **a specified negotiation mechanism. Amgen may terminate the Amgen**, in whole or in part, such agreement **Agreement in** or to seek damages. Many of our collaborators also have the right to terminate the collaboration agreement for convenience. For example, Novartis may terminate its **entirety** Collaboration and License Agreement with us at any time for any or no reason upon 90 days' **prior written notice to us**. If a collaboration agreement is terminated, in whole or in part, we may be unable to continue the development and commercialization of the applicable product candidates, and even if we are able to do so, such efforts may be delayed and result in additional costs. We may in the future determine to partner with additional pharmaceutical and biotechnology companies for development and potential commercialization of therapeutic products. We face significant competition in seeking appropriate collaborators. Our ability to reach a definitive agreement for a collaboration will depend, among other things, upon our assessment of the collaborator's resources and expertise, the terms and conditions of the proposed collaboration and the proposed collaborator's evaluation of a number of factors. If we elect to fund and undertake development or commercialization activities on our own, we may need to obtain additional expertise and additional capital, which may not be available to us on acceptable terms or at all. If we fail to enter into collaborations and do not have sufficient funds or expertise to undertake the necessary development and commercialization activities, we may not be able to further develop our product candidates or bring them to market or continue to develop our discovery platform and our business, prospects, financial condition and results of operations may be materially and adversely affected. In the future, we may rely on the use of manufacturing suites in third-party GMP facilities or third parties to manufacture our product candidates. Our business could be harmed if we are unable to use third-party manufacturing suites or if the third-party manufacturers fail to provide us with sufficient quantities of our product candidates or fail to do so at acceptable quality levels, prices, or timing. We have added manufacturing capacity at our facilities in Waltham, Massachusetts, but **we the build-out and staffing of the manufacturing suite may be delayed and the suite may never become operational.** We have not yet caused our product candidates to be manufactured or processed on a commercial scale and may not be able to do so for any of our product candidates. We expect to use third parties as part of our manufacturing process for registrational trials for our current pipeline, and we may also use them for product candidates in the future. Our anticipated reliance on a limited number of third-party manufacturers exposes us to the following risks: • we may be unable to identify manufacturers on acceptable terms or at all because the number of potential manufacturers is limited, and the FDA must inspect any manufacturers for current cGMP and cGTP compliance as part of our marketing application; • a new manufacturer would have to be educated in, or develop substantially equivalent processes for, the production of our product candidates; • our manufacturers may have little or no experience with autologous cell products, which are products made from a patient's own cells, and therefore may require a significant amount of support from us in order to implement and maintain the infrastructure and processes required to manufacture our product candidates; • our third-party manufacturers might be unable to timely manufacture our product candidates or produce the quantity and quality required to meet our clinical and commercial needs, if any; • our third-party suppliers or collaborators from whom we receive our antibodies used in combination with our product candidates may be unable to timely manufacture or provide the applicable antibody or produce the quantity and quality required to meet our clinical and commercial needs; • contract manufacturers may not be able to execute our manufacturing procedures and other logistical

support requirements appropriately; • our future contract manufacturers may not perform as agreed, may not devote sufficient resources to our product candidates or may not remain in the contract manufacturing business for the time required to supply our clinical trials or to successfully produce, store, and distribute our product, if any; • manufacturers are subject to ongoing periodic unannounced inspection by the FDA and corresponding state agencies to ensure strict compliance with cGMP, cGTP and other government regulations and corresponding foreign standards. We do not have control over third-party manufacturers' compliance with these regulations and standards; • we may not own, or may have to share, the intellectual property rights to any improvements made by our third-party manufacturers in the manufacturing process for our product candidates; • our third-party manufacturers could breach or terminate their agreements with us; • raw materials and components used in the manufacturing process, particularly those for which we have no other source or supplier, may not be available or may not be suitable or acceptable for use due to material or component defects; • our contract manufacturers and critical reagent suppliers may be subject to inclement weather, as well as natural or man-made disasters; • our contract manufacturers may have unacceptable or inconsistent product quality success rates and yields, and we have no direct control over our contract manufacturers' ability to maintain adequate quality control, quality assurance and qualified personnel; and • our contract manufacturers may be adversely affected by the ongoing COVID-19 pandemic, the ongoing U. S.- China trade war, the ongoing conflicts between Russia- Ukraine and between Israel and Hamas, political unrest in countries where we or our partners operate, earthquakes and other natural or man-made disasters, equipment failures, labor shortages, power failures, and numerous other factors. Each of these risks could delay or prevent the completion of our clinical trials or the approval of any of our product candidates by the FDA, result in higher costs or adversely impact commercialization of our product candidates. In addition, we will rely on third parties to perform certain specification tests on our product candidates prior to delivery to patients. If these tests are not appropriately done and test data are not reliable, patients could be put at risk of serious harm and the FDA could place significant restrictions on our company until deficiencies are remedied. The manufacture of biological-cellular-based drug products is complex and requires significant expertise and capital investment, including the development of advanced manufacturing techniques and process controls. Manufacturers of biologic such products often encounter difficulties in production, particularly in scaling up or out, validating the production process and assuring high reliability of the manufacturing process (including the absence of contamination). These problems include logistics and shipping, difficulties with production costs and yields, quality control, including stability of the product, intermediates, or raw materials, product testing, operator error and availability of qualified personnel, as well as compliance with strictly enforced federal, state and foreign regulations. Furthermore, if contaminants are discovered in our supply of our product candidates or in the manufacturing facilities, such manufacturing facilities may need to be closed for an extended period of time to investigate and remedy the contamination. We cannot provide assurance that any stability failures or other issues relating to the manufacture of our product candidates will not occur in the future. We may fail to manage the logistics of collecting and shipping patient material to our manufacturing site (or that of any third party we engage) and shipping the product candidate back to the patient. Logistical and shipment delays and problems caused by us, our vendors or other factors not in our control, such as weather, could prevent or delay the delivery of product candidates to patients. Additionally, we have to maintain a complex chain of identity and chain of custody with respect to patient material as it moves to the manufacturing facility, through the manufacturing process and back to the patient. Failure to maintain chain of identity and chain of custody could result in patient death, loss of product or regulatory action. Our product candidates rely on the availability of specialty materials, which may not be available to us on acceptable terms or at all. Our product candidates require specialty materials, some of which are manufactured by small companies with limited resources and experience to support a commercial product. We do not have long-term contracts with many several of these suppliers and may not be able to contract with them on acceptable terms or at all. In addition, a number of our suppliers normally support blood-based hospital businesses and generally do not have the capacity to support commercial products manufactured under cGMP by biopharmaceutical firms or may divert their resources towards hospitals rather than us. Our suppliers may be ill-equipped to support our needs, especially in non-routine circumstances like an FDA inspection or medical crisis, such as widespread contamination. We may experience delays in receiving key materials to support clinical or commercial manufacturing. For example, in 2020, we experienced significant delays in receiving shipments of materials utilized in our cell expansion process as a result of the distributor prioritizing distribution of such products for medical use, rather than product candidate development, and, subsequently, increased demand following the easing of state and federal workplace restrictions. In addition, some of our raw materials are currently sourced from a single supplier, or a small number of suppliers. For example, the type of cell culture media and cryopreservation buffer that we currently use in our manufacturing process for TSC- 100 and TSC- 101 are each only sourced from a limited number of suppliers. In addition, the cell processing equipment and tubing that we use in our current manufacturing process is only sourced from a single supplier. We also use certain biologic materials, that are available from multiple suppliers, but each version may perform differently, requiring us to characterize them and potentially modify the manufacturing process some of our protocols if we change suppliers. We cannot be sure that these suppliers will remain in business, or that they will not be purchased by one of our competitors or another company that is not interested in continuing to produce these materials for our intended purpose. Accordingly, if we no longer have access to these suppliers, we may experience delays in our clinical or commercial manufacturing which could harm our business or results of operations. Our manufacturing process needs to comply with FDA regulations relating to the quality and reliability of such processes. Any failure to comply with relevant regulations could result in delays in or termination of our clinical programs and suspension or withdrawal of any regulatory approvals. In order to commercially produce our product candidates either at our own facility or at a third party's facility, we will need to comply with the FDA's cGMP regulations and guidelines, including cGTPs. We may encounter difficulties in achieving quality control and quality assurance and may experience shortages in qualified personnel. We are subject to inspections by the FDA and comparable foreign regulatory authorities to confirm compliance with applicable regulatory requirements. Any failure to follow

cGMP, cGTP or other regulatory requirements or delay, interruption or other issues that arise in the manufacture, fill- finish, packaging, or storage of our TCR- T ~~therapy~~ candidates as a result of a failure of our facilities or the facilities or operations of third parties to comply with regulatory requirements or pass any regulatory authority inspection could significantly impair our ability to develop and commercialize our TCR- T programs, including leading to significant delays in the availability of our TCR- T ~~therapy~~ candidates for our clinical trials or the termination of or suspension of a clinical trial, or the delay or prevention of a filing or approval of marketing applications for our product candidates. Significant non- compliance could also result in the imposition of sanctions, including warning or untitled letters, fines, injunctions, civil penalties, failure of regulatory authorities to grant marketing approvals for our product candidates, delays, suspension or withdrawal of approvals, license revocation, seizures or recalls of products, operating restrictions and criminal prosecutions, any of which could damage our reputation and our business. If our third -party manufacturers use hazardous and biological materials in a manner that causes injury or violates applicable law, we may be liable for damages. Our research and development activities involve the controlled use of potentially hazardous substances, including chemical and biological materials, by our third -party manufacturers. Our manufacturing is (and any third -party manufacturers we engage are) subject to federal, state and local laws and regulations in the ~~United States~~ **U. S.** governing the use, manufacture, storage, handling and disposal of medical and hazardous materials. Although we believe that our manufacturers' procedures for using, handling, storing and disposing of these materials comply with legally prescribed standards, we cannot completely eliminate the risk of contamination or injury resulting from medical or hazardous materials. As a result of any such contamination or injury, we may incur liability or local, city, state or federal authorities may curtail the use of these materials and interrupt our business operations. In the event of an accident, we could be held liable for damages or penalized with fines, and the liability could exceed our resources. We do not have any insurance for liabilities arising from medical or hazardous materials. Compliance with applicable environmental laws and regulations is expensive, and current or future environmental regulations may impair our research, development and production efforts, which could harm our business, prospects, financial condition or results of operations. Risks Related to Employee Matters and Managing Growth We are highly dependent on our key personnel, and if we are not successful in attracting and retaining highly qualified personnel, we may not be able to successfully implement our business strategy. Our ability to compete in the highly competitive biotechnology and pharmaceutical industries depends upon our ability to attract and retain highly qualified managerial, scientific and medical personnel. We are highly dependent on our management, scientific and medical personnel. The loss of the services of any of our executive officers, other key employees and other scientific and medical advisors, and an inability to find suitable replacements could result in delays in product development and harm our business. We conduct our operations at our facility in Waltham, Massachusetts. This region is headquarters to many other biopharmaceutical companies and many academic and research institutions. Competition for skilled personnel in our market is intense and may limit our ability to hire and retain highly qualified personnel on acceptable terms or at all. Changes to U. S. immigration and work authorization laws and regulations, including those that restrain the flow of scientific and professional talent, can be significantly affected by political forces and levels of economic activity. Our business may be materially adversely affected if legislative or administrative changes to immigration or visa laws and regulations impair our hiring processes and goals or projects involving personnel who are not U. S. citizens. To encourage valuable employees to remain at our ~~company~~ **Company**, in addition to salary and cash incentives, we have provided stock options that vest over time. The value to employees of stock options that vest over time may be significantly affected by movements in our stock price that are beyond our control, and may at any time be insufficient to counteract more lucrative offers from other companies. Despite our efforts to retain valuable employees, members of our management, scientific and development teams may terminate their employment with us on short notice. Although we have employment agreements with our key employees, these employment agreements provide for at- will employment, which means that any of our employees could leave our employment at any time, with or without notice. Our success also depends on our ability to continue to attract, retain and motivate highly skilled junior, mid- level and senior managers as well as junior, mid- level and senior scientific and medical personnel. We will need to grow the size of our organization, and we may experience difficulties in managing this growth. As of ~~February 28, March 1, 2023~~ **March 1, 2024**, we had ~~137~~ **154** full- time employees and ~~10~~ **10** part- time ~~employee~~ **employees**. As our development and commercialization plans and strategies develop, and as we continue operating as a public company, we expect to need additional managerial, operational, sales, marketing, financial and other personnel, as well as additional facilities to expand our operations. Future growth would impose significant added responsibilities on members of management, including: • identifying, recruiting, integrating, maintaining and motivating additional employees; • managing our internal development efforts effectively, including the clinical and FDA review process for our product candidates, while complying with our contractual obligations to contractors and other third parties; and • improving our operational, financial and management controls, reporting systems and procedures. Our future financial performance and our ability to commercialize our product candidates will depend, in part, on our ability to effectively manage any future growth, and our management may also have to divert a disproportionate amount of its attention away from day- to- day activities in order to devote a substantial amount of time to managing these growth activities. We currently rely, and for the foreseeable future will continue to rely, in substantial part on certain independent organizations, advisors and consultants to provide certain services, including substantially all aspects of regulatory approval, and clinical trial management. There can be no assurance that the services of independent organizations, advisors and consultants will continue to be available to us on a timely basis when needed, or that we can find qualified replacements. In addition, if we are unable to effectively manage our outsourced activities or if the quality or accuracy of the services provided by consultants is compromised for any reason, our clinical trials may be extended, delayed or terminated, and we may not be able to obtain regulatory approval of our product candidates or otherwise advance our business. There can be no assurance that we will be able to manage our existing consultants or find other competent outside contractors and consultants on economically reasonable terms, or at all. If we are not able to effectively expand our organization by hiring new employees and expanding our groups of consultants and contractors, or we

are not able to effectively build out new facilities to accommodate this expansion, we may not be able to successfully implement the tasks necessary to further develop and commercialize our product candidates and, accordingly, may not achieve our research, development and commercialization goals. If product liability lawsuits are brought against us, we may incur substantial liabilities and may be required to limit commercialization of our product candidates. We face an inherent risk of product liability as a result of the planned clinical testing of our product candidates and will face an even greater risk if we commercialize any products. For example, we may be sued if our product candidates cause or are perceived to cause injury or are found to be otherwise unsuitable during clinical testing, manufacturing, marketing or sale. Any such product liability claims may include allegations of defects in manufacturing, defects in design, a failure to warn of dangers inherent in the product, negligence, strict liability or a breach of warranties. Claims could also be asserted under state consumer protection acts. If we cannot successfully defend ourselves against product liability claims, we may incur substantial liabilities or be required to limit commercialization of our product candidates. Even successful defense would require significant financial and management resources. Regardless of the merits or eventual outcome, liability claims may result in: • decreased demand for our product candidates or products that we may develop; • injury to our reputation; • withdrawal of clinical trial participants; • initiation of investigations by regulators; • costs to defend the related litigation; • a diversion of management's time and our resources; • substantial monetary awards to trial participants or patients; • product recalls, withdrawals or labeling, marketing or promotional restrictions; • loss of revenue; • exhaustion of any available insurance and our capital resources; • the inability to commercialize any product candidate; and • a decline in our share price. Failure to obtain or retain sufficient product liability insurance at an acceptable cost to protect against potential product liability claims could prevent or inhibit the commercialization of products we develop, alone or with corporate collaborators. Although we have clinical trial insurance, our insurance policies also have various exclusions, and we may be subject to a product liability claim for which we have no coverage. We may have to pay any amounts awarded by a court or negotiated in a settlement that exceed our coverage limitations or that are not covered by our insurance, and we may not have, or be able to obtain, sufficient capital to pay such amounts. Even if our agreements with any future corporate collaborators entitle us to indemnification against losses, such indemnification may not be available or adequate should any claim arise. Our ability to utilize our net operating loss carryforwards and certain other tax attributes may be limited. Under Sections 382 and 383 of the Internal Revenue Code of 1986, as amended, if a corporation undergoes an "ownership change" (generally defined as one or more shareholders or groups of shareholders who own at least 5 percent of the corporation's equity increasing their equity ownership in the aggregate by a greater than 50 percentage point change (by value) over a three- year period), the corporation's ability to use its pre- change net operating loss carryforwards and other pre- change tax attributes to offset its post- change taxable income may be limited. As a result of our initial public offering offerings, our most recent private placements and other transactions that have occurred over the past three years, we may have experienced, such an "ownership change." We may also experience ownership changes in the future as a result of subsequent shifts in our stock ownership. As of December 31, 2022 2023, we had U. S. federal net operating loss carryforwards of \$ 86.84 . 28 million and U. S. federal research and development tax credit carryforwards of \$ 6.11 . 97 million that expire through 2042 and which could be limited if we experience an "ownership change." Under the current law, federal net operating loss carryforwards generated in taxable years beginning after December 31, 2017 will not be subject to expiration. However, any such net operating loss carryforwards may only offset 80 % of our annual taxable income in taxable years beginning after December 31, 2020. State net operating loss carryforwards and other tax attributes may be similarly limited. Any such limitations may result in increased tax liabilities that could adversely affect our business, results of operations, financial position and cash flows. Risks Related to Our Common Stock and Our Status as a Public Company We do not know whether an active trading market will continue to develop or be sustained for our common stock and, as a result, it may be difficult for our stockholders to sell their shares of our common stock. Our common stock began trading on the Nasdaq Global Market in July 2021. Prior to July 2021, there was no public market for our common stock, and we cannot assure you that an active trading market for our shares will continue to develop or be sustained. As a result, it may be difficult for our stockholders to sell their shares without depressing the market price of our common stock, or at all. The price of our common stock is volatile and fluctuates substantially, which could result in substantial losses for our stockholders. Our stock price has been, and is likely to continue to be, volatile. The stock market in general, and the market for smaller biopharmaceutical companies in particular, have experienced extreme price volatility and volume fluctuations that have often been unrelated to the operating performance of particular companies. As a result of this volatility, our stockholders may not be able to sell their common stock at or above the price they paid for their shares. The market price for our common stock may be influenced by many factors, including: • overall performance of the equity markets; • our operating performance and the performance of other similar companies; • results from our ongoing clinical trials and future clinical trials with our current and future product candidates or of our competitors; • delays in the commencement, enrollment and the ultimate completion of clinical trials; • changes in our projected operating results that we provide to the public, our failure to meet these projections or changes in recommendations by securities analysts that elect to follow our common stock; • regulatory actions with respect to our product candidates; • regulatory or legal developments in the United States U. S. and other countries; • the level of expenses related to future product candidates or clinical development programs; • our failure to achieve product development or commercialization goals or regulatory approval milestones in the timeframe we announce; • changes in hospital or emergency care partner practices; • announcements of acquisitions, strategic alliances or significant agreements by us or by our competitors; • developments or disputes concerning intellectual property or proprietary rights; • our ability to obtain, maintain, protect and enforce our intellectual property and proprietary rights; • recruitment or departure of key personnel; • the economy as a whole and market conditions in our industry, including conditions resulting from the COVID- 19 pandemic; or the ongoing conflict conflicts between Russia and Ukraine and between Israel and Hamas; • variations in our financial results or the financial results of companies that are perceived to be similar to us; • financing or other corporate transactions, or inability to obtain additional funding; • trading activity by a limited number of stockholders who together beneficially own a substantial amount of

our outstanding common stock; • the expiration of market standoff or contractual lock- up agreements, as applicable; • the size of our market float; and • the other factors described in this “ Risk Factors ” section. In addition, the stock markets have experienced extreme price and volume fluctuations that have affected and continue to affect the market prices of equity securities of many biopharmaceutical companies. Stock prices of many biopharmaceutical companies have fluctuated in a manner unrelated or disproportionate to the operating performance of those companies. In the past, stockholders have filed securities class action litigation following periods of market volatility. If we were to become involved in securities litigation, it could subject us to substantial costs, divert resources and the attention of management from our business and adversely affect our business. If securities or industry analysts do not publish research or publish inaccurate or unfavorable research about our business, our stock price and trading volume could decline. The trading market for our common stock will depend in part on the research and reports that securities or industry analysts publish about us or our business. If no or only very few securities analysts commence coverage of us, or if industry analysts cease coverage of us, the trading price for our common stock would be negatively affected. If one or more of the analysts who cover us downgrade our common stock or publish inaccurate or unfavorable research about our business, our common stock price would likely decline. If one or more of these analysts cease coverage of us or fail to publish reports on us regularly, demand for our common stock could decrease, which might cause our common stock price and trading volume to decline. Substantial amounts of our outstanding shares may be sold into the market. If there are substantial sales of shares of our common stock, the price of our common stock could decline. The price of our common stock could decline if there are substantial sales of our common stock, particularly sales by our directors, executive officers and significant stockholders, or if there is a large number of shares of our common stock available for sale and the market perceives that sales will occur. Shares held by directors, executive officers and their affiliates will be subject to volume limitations or other restrictions under Rule 144 under the Securities Act of 1933, as amended, or the Securities Act, and various vesting agreements. Certain of our stockholders have rights, subject to some conditions above, to require us to file registration statements covering their shares or to include their shares in registration statements that we may file for ourselves or our stockholders. In addition, the Loan Agreement with K2HV provides the lenders with certain registration rights with respect to the Conversion Shares (as defined in the Loan Agreement). Pursuant to the terms of the Loan Agreement, we are obligated to prepare and file with the SEC a registration statement to register the Conversion Shares for resale upon request of K2HV. We also have registered shares of common stock that we have issued and may issue under our employee equity incentive plans. Once we register these shares, they will be able to be sold freely in the public market upon issuance. The market price of the shares of our common stock could decline as a result of the sale of a substantial number of our shares of common stock in the public market or the perception in the market that the holders of a large number of shares intend to sell their shares. The concentration of our stock ownership will likely limit our stockholders’ ability to influence corporate matters, including the ability to influence the outcome of director elections and other matters requiring stockholder approval. As of ~~February 28~~ **March 1, 2023-2024**, our executive officers, directors, and entities affiliated with such persons beneficially owned, in the aggregate, approximately ~~22-32~~ % of our outstanding voting stock and approximately ~~35-38~~ % of our outstanding common stock. As a result, these stockholders, acting together, have significant influence over all matters that require approval by our stockholders, including the election of directors and approval of significant corporate transactions. Corporate actions might be taken even if other stockholders, oppose them. This concentration of ownership may prevent or discourage unsolicited acquisition proposals or offers for our common stock that you or other stockholders may feel are in your or their best interest as one of our stockholders. This concentration of ownership might also have the effect of delaying or preventing a change of control of our ~~company~~ **Company** that other stockholders may view as beneficial. In addition, we entered into a nominating agreement with Baker Brothers Life Sciences, L. P. and 667, L. P. (collectively, the BBA Funds) which was subsequently amended and restated on April 22, 2021), pursuant to which, among other things, we agreed to support the nomination of, and cause our board of directors (or the nominating committee thereof) to include in the slate of nominees recommended to our stockholders for election as directors at each annual or special meeting of our stockholders at which directors are to be elected, one person designated from time to time by the BBA Funds, subject to the requirements of fiduciary duties under applicable law and the terms and conditions of such nominating agreement. The agreement only applies for the three years following our initial public offering, as long as (1) the BBA Funds and their affiliates, collectively, beneficially own at least 75 % of the shares of our common stock issued upon conversion of the Series C convertible preferred stock purchased by the BBA Funds in our Series C convertible preferred stock financing, and (2) the BBA Funds and their affiliates, collectively, beneficially own at least 2 % of our then outstanding voting common stock. We are an “ emerging growth company ” and a “ smaller reporting company, ” and we cannot be certain if the reduced reporting requirements applicable to emerging growth companies and smaller reporting companies will make our common stock less attractive to investors. We are an “ emerging growth company ” as defined in the JOBS Act and we intend to take advantage of some of the exemptions from reporting requirements that are applicable to other public companies that are not emerging growth companies, including: • the option to present only two years of audited financial statements, in addition to any required unaudited interim financial statements, with correspondingly reduced “ Management’ s Discussion and Analysis of Financial Condition and Results of Operations ” disclosure; • not being required to comply with the auditor attestation requirements of Section 404 (b) of the Sarbanes Oxley Act; • not being required to comply with any requirement that may be adopted by the Public Company Accounting Oversight Board regarding mandatory audit firm rotation or a supplement to the auditor’ s report providing additional information about the audit and the financial statements; • not being required to disclose certain executive compensation- related items such as the correlation between executive compensation and performance and comparisons of the chief executive officer’ s compensation to median employee compensation; and • not being required to submit certain executive compensation matters to stockholder advisory votes, such as “ say- on- pay, ” “ say- on- frequency, ” and “ say- on- golden parachutes. ” The JOBS Act permits an “ emerging growth company ” such as us to take advantage of an extended transition period to comply with new or revised accounting standards applicable to public companies.

We have elected to take advantage of this extended transition period. We cannot predict if investors will find our common stock less attractive because we will rely on these exemptions. If some investors find our common stock less attractive as a result, there may be a less active trading market for our common stock and our stock price may be more volatile. We may take advantage of these reporting exemptions until we are no longer an emerging growth company. We will remain an emerging growth company until the earlier of (1) the last day of the fiscal year (a) ending December 31, 2026, (b) in which we have total annual gross revenue of at least \$ 1.235 billion or (c) in which we are deemed to be a large accelerated filer, which means the market value of our common stock that is held by non-affiliates exceeds \$ 700 million as of the prior June 30th and (2) the date on which we have issued more than \$ 1.0 billion in non-convertible debt during the prior three-year period. Even after we no longer qualify as an emerging growth company, we may still qualify as a “smaller reporting company,” which would allow us to continue to take advantage of many of the same exemptions from disclosure requirements, including not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act, **as amended (Sarbanes-Oxley Act)**, and reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements. We cannot predict if investors will find our common stock less attractive because we may rely on these exemptions. If some investors find our common stock less attractive as a result, there may be a less active trading market for our common stock and our stock price may be more volatile. Requirements associated with being a public company will increase our costs significantly, as well as divert significant company resources and management attention. As a public company, and particularly after we are no longer an “emerging growth company,” we will incur significant legal, accounting and other expenses that we did not incur as a private company, including costs associated with public company reporting requirements. We also anticipate that we will incur costs associated with relatively recently adopted corporate governance requirements, including requirements of the SEC, and the Nasdaq Global Market. We expect these rules and regulations to increase our legal and financial compliance costs and to make some activities more time-consuming and costly. We also expect that these rules and regulations may make it more difficult and more expensive for us to obtain director and officer liability insurance and we may be required to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage. As a result, it may be more difficult for us to attract and retain qualified individuals to serve on our board of directors or as executive officers. If we fail to maintain proper and effective internal controls, our ability to produce accurate and timely financial statements could be impaired, which could result in sanctions or other penalties that would harm our business. Effective internal controls over financial reporting are necessary for us to provide reliable financial reports and, together with adequate disclosure controls and procedures, are designed to prevent fraud. Any failure to implement required new or improved controls, or difficulties encountered in their implementation could cause us to fail to meet our reporting obligations. In addition, any testing by us conducted in connection with ~~Section 404 of the Sarbanes-Oxley Act~~ **Section 404 of the Sarbanes-Oxley Act** of 2002, ~~as amended, or the Sarbanes-Oxley Act,~~ or any subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses or that may require prospective or retroactive changes to our financial statements or identify other areas for further attention or improvement. Inferior internal controls could also cause investors to lose confidence in our reported financial information, which could have a negative effect on the trading price of our stock. We are required to disclose changes made in our internal controls and procedures on a quarterly basis and our management will be required to assess the effectiveness of these controls annually. However, for as long as we are an “emerging growth company” under ~~the Jumpstart Our Business Startups Act, or the~~ **the Jumpstart Our Business Startups Act, or the** JOBS Act, ~~enacted in April 2012,~~ our independent registered public accounting firm will not be required to attest to the effectiveness of our internal controls over financial reporting pursuant to ~~Section 404 of~~ **Section 404 of** the Sarbanes-Oxley Act. We could be an “emerging growth company” until December 31, 2026. An independent assessment of the effectiveness of our internal controls over financial reporting could detect problems that our management’s assessment might not. Undetected material weaknesses in our internal controls over financial reporting could lead to financial statement restatements and require us to incur the expense of remediation. We will have broad discretion in the use of our cash and cash equivalents and may not use them effectively. We will have broad discretion in the application of our cash and cash equivalents, including working capital and other general corporate purposes, and our stockholders may disagree with how we spend or invest these proceeds. We may spend our funds in ways that do not improve our results of operations or enhance the value of our common stock. The failure by our management to apply these funds effectively could adversely affect our business and financial condition. Pending their use, we may invest our cash and cash equivalents in a manner that does not produce income or that loses value. These investments may not yield a favorable return to our stockholders. We do not intend to pay dividends for the foreseeable future. We have never declared nor paid cash dividends on our capital stock. We currently intend to retain any future earnings to finance the operation and expansion of our business, and we do not expect to declare or pay any dividends in the foreseeable future. Consequently, stockholders must rely on sales of their common stock after price appreciation, which may never occur, as the only way to realize any future gains on their investment. Our operating results may fluctuate significantly, which makes our future operating results difficult to predict and could cause our operating results to fall below expectations or our guidance. Our quarterly and annual operating results may fluctuate significantly in the future, which makes it difficult for us to predict our future operating results. Our operating results may fluctuate due to a variety of factors, many of which are outside of our control and may be difficult to predict, including the following: • the timing and success or failure of clinical trials for our product candidates or competing product candidates, including the nature of the data obtained from such clinical trials, or any other change in the competitive landscape of our industry, including consolidation among our competitors or partners; • our ability to successfully recruit patients for preclinical studies and clinical trials, and any delays caused by difficulties in such recruitment efforts; • our ability to obtain regulatory approval for our product candidates, and the timing and scope of any such approvals we may receive; • the timing and cost of, and level of investment in, research and development activities relating to our product candidates, which may change from time to time; • the cost of manufacturing our product candidates, which may vary depending on the quantity of production and the

terms of our agreements with manufacturers; • our ability to attract, hire and retain qualified personnel; • expenditures that we will or may incur to develop additional product candidates; • the level of demand for our product candidates should they receive approval, which may vary significantly; • the risk / benefit profile, cost and reimbursement policies with respect to our product candidates, if approved, and existing and potential future drugs that compete with our product candidates; • the changing and volatile U. S., European and global economic environments, including impact of the COVID-19 pandemic; and • future accounting pronouncements or changes in our accounting policies. The cumulative effects of these factors could result in large fluctuations and unpredictability in our quarterly and annual operating results. As a result, comparing our operating results on a period- to- period basis may not be meaningful. This variability and unpredictability could also result in our failing to meet the expectations of industry or financial analysts or investors for any period. If our revenue or operating results fall below the expectations of analysts or investors or below any forecasts we may provide to the market, or if the forecasts we provide to the market are below the expectations of analysts or investors, the price of our common stock could decline substantially. Such a stock price decline could occur even when we have met any previously publicly stated guidance we may provide. Delaware law and provisions in our amended and restated certificate of incorporation and amended and restated bylaws could make a merger, tender offer or proxy contest difficult, thereby depressing the trading price of our common stock. Our status as a Delaware corporation and the anti- takeover provisions of the Delaware General Corporation Law may discourage, delay or prevent a change in control by prohibiting us from engaging in a business combination with an interested stockholder for a period of three years after the person becomes an interested stockholder, even if a change of control would be beneficial to our existing stockholders. In addition, our amended and restated certificate of incorporation and amended and restated bylaws contain provisions that may make the acquisition of our company **Company** more difficult, including the following: • a classified board of directors with three- year staggered terms, which could delay the ability of stockholders to change the membership of a majority of our board of directors; • the ability of our board of directors to issue shares of preferred stock and to determine the price and other terms of those shares, including preferences and voting rights, without stockholder approval, which could be used to significantly dilute the ownership of a hostile acquiror; • the exclusive right of our board of directors to elect a director to fill a vacancy created by the expansion of our board of directors or the resignation, death or removal of a director, which prevents stockholders from being able to fill vacancies on our board of directors; • a prohibition on stockholder action by written consent, which forces stockholder action to be taken at an annual or special meeting of our stockholders; • the requirement that a special meeting of stockholders may be called only by a majority vote of our entire board of directors, the chairman of our board of directors or our chief executive officer, which could delay the ability of our stockholders to force consideration of a proposal or to take action, including the removal of directors; • the requirement for the affirmative vote of holders of at least 66 2 / 3 % of the voting power of all of the then- outstanding shares of the voting stock, voting together as a single class, to amend the provisions of our amended and restated certificate of incorporation or our amended and restated bylaws, which may inhibit the ability of an acquiror to effect such amendments to facilitate an unsolicited takeover attempt; and • advance notice procedures with which stockholders must comply to nominate candidates to our board of directors or to propose matters to be acted upon at a stockholders' meeting, which may discourage or deter a potential acquiror from conducting a solicitation of proxies to elect the acquiror' s own slate of directors or otherwise attempting to obtain control of us. In addition, as a Delaware corporation, we are subject to Section 203 of the Delaware General Corporation Law. These provisions may prohibit large stockholders, in particular those owning 15 % or more of our outstanding voting stock, from merging or combining with us for a certain period of time. A Delaware corporation may opt out of this provision by express provision in its original certificate of incorporation or by amendment to its certificate of incorporation or bylaws approved by its stockholders. However, we have not opted out of this provision. These and other provisions in our amended and restated certificate of incorporation, amended and restated bylaws and Delaware law could make it more difficult for stockholders or potential acquirors to obtain control of our board of directors or initiate actions that are opposed by our then- current board of directors, including delay or impede a merger, tender offer or proxy contest involving our company **Company**. The existence of these provisions could negatively affect the price of our common stock and limit opportunities for stockholders to realize value in a corporate transaction. Our amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware and the federal district courts of the **United States U. S.** is the exclusive forum for substantially all disputes between us and our stockholders, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers or employees. Our amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware is the exclusive forum for any derivative action or proceeding brought on our behalf, any action asserting a breach of fiduciary duty, any action asserting a claim against us arising pursuant to the Delaware General Corporation Law, our certificate of incorporation or our bylaws or any action asserting a claim against us that is governed by the internal affairs doctrine. This provision does not apply to claims brought to enforce a duty or liability created by the Exchange Act or any other claim for which the federal courts have exclusive jurisdiction. Our amended and restated certificate of incorporation provides further that the federal district courts of the **United States U. S.** is the exclusive forum for resolving any complaint asserting a cause of action arising under the Securities Act. These choices of forum provisions may limit a stockholder' s ability to bring a claim in a judicial forum that it finds favorable for disputes with us or our directors, officers or other employees and may discourage these types of lawsuits. Furthermore, the enforceability of similar choice of forum provisions in other companies' certificates of incorporation has been challenged in legal proceedings, and it is possible that a court could find these types of provisions to be inapplicable or unenforceable. While the Delaware courts have determined that such choice of forum provisions are facially valid, a stockholder may nevertheless seek to bring a claim in a venue other than those designated in the exclusive- forum provisions, and there can be no assurance that such provisions will be enforced by a court in those other jurisdictions. If a court were to find the exclusive- forum provision contained in our amended and restated certificate of incorporation to be inapplicable or unenforceable in an action, we may incur additional costs associated with resolving such action in other jurisdictions, which

could harm our business. Changes in tax legislation could adversely affect our business and financial condition. The rules dealing with U. S. federal, state, and local income taxation are constantly under review by persons involved in the legislative process and by the Internal Revenue Service and the U. S. Treasury Department. Changes to tax laws (which changes may have retroactive application) could adversely affect us or holders of our common stock. In recent years, many such changes have been made and changes are likely to continue to occur in the future. **For example, under Section 174 of the Internal Revenue Code of 1986, as amended, in taxable years beginning after December 31, 2021, expenses that are incurred for research and development in the U. S. will be capitalized and amortized, which may have an adverse effect on our cash flow.** It cannot be predicted whether, when, in what form, or with what effective dates, new tax laws may be enacted, or regulations and rulings may be promulgated or issued under existing or new tax laws, which could result in an increase in our or our shareholders' tax liability or require changes in the manner in which we operate in order to minimize or mitigate any adverse effects of changes in tax law or in the interpretation thereof. **Rising inflation rates may result in increased operating costs and reduced liquidity, and affect our ability to access credit.** Increased inflation may result in increased operating costs (including our labor costs), reduced liquidity, and limitations on our ability to access credit or otherwise raise debt and equity capital. In addition, the ~~United States~~ **U. S.** Federal Reserve System has repeatedly raised, and may continue to raise, interest rates in response to concerns about inflation. Increases in interest rates, especially if coupled with reduced government spending and volatility in financial markets, may have the effect of further increasing economic uncertainty and heightening these risks. We could be subject to securities class action litigation. In the past, securities class action litigation has often been brought against a company following a decline in the market price of its securities. This risk is especially relevant for us because biopharmaceutical companies have experienced significant stock price volatility in recent years. If we face such litigation, it could result in substantial costs and a diversion of management's attention and resources, which could harm our business. Business disruptions could seriously harm our future revenue and financial condition and increase our costs and expenses. Our operations, and those of our CROs, CMOs and other contractors and consultants, could be subject to earthquakes, power shortages, telecommunications failures, water shortages, floods, hurricanes, typhoons, fires, extreme weather conditions, medical epidemics and other natural or man- made disasters or business interruptions, for which we are predominantly self-insured. The occurrence of any of these business disruptions could seriously harm our operations and financial condition and increase our costs and expenses. Our ability to obtain clinical supplies of our product candidates could be disrupted if the operations of these suppliers are affected by a man- made or natural disaster or other business interruption. ~~112~~