

F5 Networks, Inc.

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F5 Networks, Inc. Employee Benefit Plan

Effective October 1, 2019

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F5 Networks, Inc. Employee Benefit Plan

INTRODUCTION

F5 Networks, Inc. ("Company"), a C Corporation, hereby adopts, an "employee welfare benefit plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), known as the F5 Networks, Inc. Employee Benefit Plan (hereinafter the "Plan"), originally established October 1, 2017, the terms of which are set forth in this Plan document and the underlying Welfare Program documents. Effective as of October 1, the F5 Networks, Inc. Employee Benefit Plan, Plan number 505, became administered as a single program or arrangement. The Plan provides for the payment or reimbursement of certain benefits for Eligible Employees (and certain eligible dependents of such Employees), as well as such other trades or businesses designated by a proper officer of the Employer that include, but are not limited to: Medical/Rx, Dental, Life, AD&D, STD, LTD, and Health Care and Day Care FSA benefits.

The purpose of this Plan document is to set forth the essential terms and provisions of the Plan and to consolidate and combine into a single Plan document certain Welfare Programs maintained by the Employer, and to provide Participants and their beneficiaries with the benefits described herein and in the Welfare Programs, which are incorporated by reference into this Plan. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single benefit plan to the extent permitted under ERISA. The Plan is intended to meet all applicable requirements of ERISA, as well as rulings and regulations issued thereunder. Terms that are capitalized are defined in the Article titled: "Definitions."

Contributions are made by the Employer and Eligible Employees. These contributions are based on the amount of insurance premiums and costs necessary to provide the coverage under the Plan. The level of Employee contributions is established by the Employer annually. All group benefits underwritten by an Insurance Company are paid solely from the general assets of the Insurance Company. All group benefits self-funded by the Employer are paid solely from the general assets of the Employer.

The payment of all benefits under the Plan is expressly subject to all the provisions, including amendments, of this Plan document, as well as the terms and conditions of the Welfare Programs, including amendments/riders to said Welfare Programs (the terms of which are incorporated herein by reference).

In the event that the provisions of any Welfare Program conflict with the provisions of this Plan document or any other Welfare Program, the Plan Administrator shall, in its discretion, interpret the terms and purpose of the Plan so as to resolve any conflict. However, the terms of this Plan document may not increase the rights of a Participant or a Participant's beneficiary to benefits available under any Welfare Program.

I. ARTICLE - DEFINITIONS

1. **"Claims Administrator"** shall mean the organization appointed by the Plan Administrator as responsible for benefits administration under a Welfare Program. In the case of an insured Welfare Program, the Claims Administrator shall mean the Insurance Company.
2. **"Eligible Employee"** shall mean an Employee who satisfies the eligibility provisions of the Article titled "Benefits," Section 1, including the eligibility provisions of the applicable component benefit program.
3. **"Dependent"** shall include:
 - any child of a Plan Participant who is covered under an Insurance Contract, as defined in the Contract or under applicable law
 - any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only, or
 - any Child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609.

4. **"Employee,"** except as otherwise defined in a Welfare Program, shall mean any individual who is employed by the Employer as a common-law employee as shown on applicable payroll records.

In addition, the term "Employee" shall not include any individual who, in good faith, is classified as an independent contractor by the Employer, even if such individual is later determined by any governmental agency or court to have been a common law employee of the Employer.

5. **"Employer"** shall mean F5 Networks, Inc., a C Corporation and its successors and assigns.
6. **"Entry Date"** means the date on which an Eligible Employee has satisfied the enrollment requirements of this Plan or such Welfare Program, as specified by the Plan Administrator, and becomes a Participant in this Plan or such Welfare Program.
7. **"ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended.
8. **"Grandfathered Health Plan Status"** as permitted by the PPACA regulations, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. The PPACA allows health plans that existed on March 23, 2010, to be grandfathered, and thus, be exempt from some of the law's provisions, for as long as it maintains the "grandfathered" status under the applicable regulations.

Example: Grandfathered Plan - is not required to cover preventive health services without cost sharing. But the plan must comply with certain other protections of PPACA, i.e., the elimination of lifetime limits on essential health benefits.

9. **"Insurance Company" or "Insurance Companies"** means any Insurance Company licensed to do business in the State of the Employer and/or such other States in which the Employer does business, and with which the Employer has entered into a contract for the purposes of providing benefits under the Plan.
10. **"Participant"** means an Eligible Employee who has satisfied the enrollment requirements of this Plan or a Welfare Program, as specified by the Plan Administrator, and is enrolled in this Plan or such Welfare Program.
11. **"Plan"** shall refer to the F5 Networks, Inc. Employee Benefit Plan, as amended.
12. **"Plan Administrator"** shall refer to the Employer, unless the Employer has designated another person, committee, or entity to act in its place, as provided in the Section titled: "Named Fiduciaries."

13. **"Plan Year"** means the 12-month period beginning October 1 and ending September 30. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during the middle of a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's entry date and ending on the last day of such Plan Year.
14. **"Policy" or "Policies"** shall mean the insurance contracts, as such contract or contracts may be amended or replaced with other insurance contracts, issued to the Employer by an Insurance Company or Insurance Companies (or such other contracts between the Employer and a benefit provider) for the purpose of providing benefits under the Plan. All such Policies, the terms of which are incorporated herein by reference, shall be considered a part of this Plan.
15. **"PPACA"** means the Patient Protection and Affordable Care Act, as amended.
16. **"Rule of Parity"** means the Employer option to treat an Employee who has a break in service (no credited hours of service for a minimum of 4 weeks) that was longer than the Employee's period of service immediately preceding the break, as a new hire upon return to active service, e.g., if the Employee only worked credited hours for 4 weeks, then had a break in service of 6 weeks, the Employee is treated as a new hire.
17. **"Special Unpaid Leave"** shall mean unpaid leave subject to FMLA, USERRA, or because of jury duty, as applicable to the look-back measurement method under ACA rules.
18. **"Spouse"** means (a) for purposes of an insured Welfare Program, a Participant's spouse as defined in the underlying Policy or Policies; and (b) for purposes of a self-funded Welfare Program, a person legally married to a Participant under state law, including common law spouses, unless legally separated by court decree; provided, however, in the case of both subsection (a) and subsection (b) that the Plan Administrator may require the Participant to provide evidence of marriage, which may include a marriage certificate or other official documentation satisfactory to the Plan Administrator. The Plan Administrator has the sole and absolute authority to determine an individual's status as a spouse of a Participant for the purposes of the Plan, and any such determination shall be final, binding, and conclusive on all parties ever claiming an interest in the Plan. Spouse shall also mean "domestic partner" if designated by the Plan Administrator; provided, however, that the Plan Administrator may require the Participant to provide evidence of the domestic partnership, which may include a declaration of facts or other official documentation satisfactory to the Plan Administrator.
19. **"Summary Plan Description"** shall mean the F5 Networks, Inc. Employee Benefit Plan Summary Plan Description, a document that describes the specific benefits under the Plan. The Summary Plan Description, as amended or as restated from time to time, shall be considered a part of the Plan, and is incorporated herein by reference.
20. **"Welfare Program"** shall mean each item identified in Appendix A, as it may be updated from time to time. The terms of each Welfare Program, as they may be set out in the Policies, contracts, or other documents with respect to the Welfare Program, shall form a part of this Plan in the same manner as if all the terms and provisions thereof were included in this Plan document.

Any Welfare Programs and the corresponding Appendix A will also include any and all amendments, or replacement plans, or documents, and summaries, policies, and contracts, if any, for such period(s) during which the document is in effect. Any amendment or replacement of any of the documents comprising the Welfare Programs and of Appendix A, may be certified by a duly authorized officer of the Company, and may be updated as required, without any need to amend this document.

II. ARTICLE - BENEFITS

1. **Eligibility and Participation.** The eligibility and participation requirements for each Welfare Program are stated in the applicable Policy or Welfare Program document.

An Eligible Employee with respect to the Plan is any Employee who is eligible to participate in one or more of the component Welfare Programs in accordance with the terms and conditions of the Plan (including the terms of the applicable component Welfare Program).

Where the eligibility and/or participation requirements are not stated in the Policy or Welfare Program document, the following eligibility and/or participation requirements shall apply:

Eligible Employees	Benefits	
	Medical and Dental	Life, AD&D, STD, LTD, Health Care and Day Care FSAs
Intern and Temporary Employee Regularly Scheduled to Work ≥20 Hours Per Week	Available on Date of Hire*	Not Available
Regular Part-Time Employee Regularly Scheduled to Work ≥20 Hour Per Week, but <30 Hours	Available on Date of Hire*	Not Available
Regular Full-Time Employee Regularly Scheduled to Work ≥30 Hours Per Week	Available on Date of Hire*	Available on Date of Hire or Date You Become a Regular Full-Time Employee*

*Subject to completing enrollment and submitting any required forms

Eligible Employees need to enroll within 31 days of their initial eligibility date or they will automatically be enrolled in the high deductible health plan and dental plan with employee only coverage. In addition, all regular full-time employees working 30 hours or more will also be automatically enrolled in the following programs: Basic Life and AD&D, STD, LTD, Employee Assistance Program, Emergency Travel Assistance, Travel Accident Insurance, and Identity Theft Assistance.

Additional documents may be required as part of the enrollment process when the Eligible Employee is applying for optional life insurance for themselves and a spouse, insuring a domestic partner, or waiving F5's medical and/or dental coverage. If F5's Benefits Team does not receive such required documents, which may include an Evidence of Insurability application, Waiver form, or Domestic Partnership Registration or Affidavit, as applicable within 31 days of an Eligible Employee's initial eligibility date, the election requiring such documents will be canceled.

Other individuals, such as an Eligible Employee's spouse, children, or other designated member, may be eligible to participate in and receive benefits under one or more of the Welfare Programs due to their relationship to an Eligible Employee. Information about such eligibility and coverage is found in the applicable Policy or Welfare Program Documents.

With respect to any waiting period for initial enrollment under any Welfare Program, the Plan Administrator may provide for the crediting of prior service for Employees of participating employers involved in an acquisition, merger, or similar transaction with the Employer.

2. **Termination of Participation.** Participation under the Plan shall cease when the Participant ceases to participate in all Welfare Programs, as stated in the applicable Policy or Welfare Program document, or for non-payment of the cost share of a Participant and/or other covered person.

Subject to the terms and conditions of any applicable Welfare Plan, if an Eligible Employee stops working, and is rehired or resumes providing services to the Employer, he or she may enter (or reenter) the Plan when he or she once again meets the eligibility requirements set forth within this Plan.

Notwithstanding the foregoing, participation under the Plan shall cease upon the latest of the following two dates: (a) the last day of FMLA leave as required by law, or (b) the day the participant no longer qualifies as an Eligible Employee and has exhausted all approved leave (e.g., personal, sick, vacation, etc.) or disability leave as determined by the Employer.

3. **Benefits.** Participants shall receive benefits under the Welfare Programs. Benefits shall be determined exclusively by the terms of the Welfare Programs, including eligibility for coverage, levels and amounts of coverage, the terms and conditions of coverage, and when coverage begins and terminates. Benefits will be paid solely in the form and in the amount set forth under the Welfare Programs.

All of the benefits under the Plan are described in more detail in the Policies and Welfare Programs, the terms of which are incorporated herein and made a part hereof by reference. In the case of any conflict between the terms of the Plan document and the terms of the Policies or Welfare Programs with respect to benefits owed, the terms of the Policies or Welfare Programs (as applicable) shall control.

4. **Funding.** The terms of each Welfare Program shall govern the amount and timing of any Participant contribution required to be made for coverage. Nothing herein requires an Employer to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant or his or her Spouse or Dependent, except to the extent specifically required under the terms of a Welfare Program. No Participant or beneficiary shall have any right to, or interest in the assets of the Employer.

III. ARTICLE - ADMINISTRATION OF THE PLAN

1. **Named Fiduciaries.**

The following persons or entities are named fiduciaries under the Plan:

F5 Networks, Inc.
801 5th Avenue
Seattle, WA 98104

The following shall be the Plan Administrator:

F5 Networks, Inc.
801 5th Avenue
Seattle, WA 98104

The Plan Administrator shall be solely responsible for the administration of the Plan, unless this function is explicitly delegated to another named fiduciary under this article. The Employer may, from time to time, duly appoint another person, committee, or entity to be the Plan Administrator, or perform certain functions thereof. In the absence of such appointment, the Employer shall serve as the Plan Administrator.

The Employer may enter into an agreement with an Insurance Company for the purpose of insuring all or part of the benefits under the Plan and for administering certain benefits provided by the Plan. However, the Insurance Company shall only be a fiduciary with respect to the Plan to the extent that the Insurance Company exercises any discretionary authority or control with respect to the management of the Plan, or exercises any authority or control with respect to management or disposition of assets, renders investment advice for a fee or other compensation, direct or indirect, with respect to any monies or other property of the Plan, or has any authority or responsibility to do so, has any discretionary authority or responsibility in the administration of the Plan, or otherwise agrees to be a fiduciary with respect to the Plan.

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. Any named fiduciary hereunder may, pursuant to such other formal procedures as it shall establish, designate persons (including third party administrators) other than the named fiduciaries to carry out its fiduciary responsibilities under the Plan.

2. **Complete and Separate Allocation of Fiduciary Responsibilities.** It is intended that this Plan shall allocate to each named fiduciary individual responsibility for the prudent execution of the functions assigned thereto. The performance of such responsibilities shall be deemed a several assignment and not a joint assignment. No responsibility is intended to be shared by two (2) or more of such fiduciaries, unless such sharing shall be provided by a specific provision of the Plan. Whenever one named fiduciary is required by the Plan to follow the directions of another named fiduciary, the two shall not be deemed to have been assigned a shared responsibility. The fiduciary giving the direction shall be deemed to have that action as its sole responsibility, and the responsibility of the fiduciary receiving such direction shall be to follow the direction insofar as such direction is on its face proper under the terms of the Plan and applicable law.
3. **Plan Administrator.** The administration of the Plan is under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them. The Plan Administrator has full power to administer and interpret the Plan in all of its details, subject to applicable requirements of law. For this purpose, except to the extent otherwise provided under the terms of any Welfare Program, the Plan Administrator's powers include, but are not limited to, the following authority, in addition to all other powers provided by this Plan:

- a. The authority to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of claims procedures;
- b. The authority to compile and maintain all Plan records it deems necessary for the administration of the Plan;
- c. The authority to prepare and distribute information regarding the Plan, and to obtain from the Employer, Employees, Participants, and other covered persons such information as is necessary for the proper administration of the Plan;
- d. The complete discretion to interpret the provisions of the Plan, including but not limited to determinations regarding eligibility for participation in and coverage under the Plan, and the types and amounts of benefits payable under the Plan, and to make all necessary findings of fact. The Plan Administrator's interpretations in good faith shall be final and conclusive on all persons claiming benefits under the Plan. Decisions by the Plan Administrator may not be overturned unless found by a court to be arbitrary and capricious and to have no reasonable foundation;
- e. The authority to appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan;
- f. The authority to allocate and delegate its responsibilities under the Plan, and to designate other persons to carry out any of its responsibilities under the Plan;
- g. The authority to enter into any and all contracts and agreements for carrying out the terms of this Plan and for the administration of the Plan, and to do all acts as the Plan Administrator, in its sole discretion, may deem necessary or advisable. Such contracts and agreements shall be binding and conclusive on the parties hereto and anyone claiming benefits hereunder;
- h. The authority to sue or to cause suit to be brought in the name of the Plan and to compromise and settle claims brought against, by, or on behalf of the Plan; and
- i. The authority take any other action necessary or advisable to carry out its duties with respect to the Plan.

Notwithstanding the foregoing, to the extent the benefits under any Welfare Program are provided under a fully insured arrangement, the Insurance Company for such program shall have the responsibility for determining entitlement to benefits under the program and prescribing the claims procedures to be followed by Participants and beneficiaries thereunder. Such Insurance Company will act as a named fiduciary of the Plan with respect to such Welfare Program and will have the full power to interpret and apply the terms of such insured Welfare Program as they relate to benefits provided thereunder.

Benefits under the Plan will be paid only if the Plan Administrator decides, in its sole and absolute discretion, that payment is merited pursuant to the terms of the Plan. Notwithstanding the foregoing, any claim which arises under a Policy is not subject to review under this Plan, and the Plan Administrator's authority does not extend to any matter as to which any other person or entity is empowered to make determinations under such Policy or documents evidencing such arrangement.

4. **Disclaimer of Liability.** Except as otherwise provided under Sections 404 through 409 of ERISA, neither the Employer, nor any person designated to carry out fiduciary responsibilities pursuant to this Section of the Plan, shall be liable for any act, or failure to act, that is made in good faith pursuant to the provisions of the Plan.

All Plan fiduciaries who are also employees or officers of the Plan Administrator or any Employer shall be fully indemnified by the Employer against all liabilities, costs, and expenses (including but not limited to reasonable attorneys' fees and costs) imposed upon them in connection with any action,

suit, or proceeding to which he or she may be a party by reason of being a Plan fiduciary and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

Unless liability is otherwise provided under Section 405 of ERISA, a fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

5. **Reliance on Tables, Etc.** In administering the Plan, the Plan Administrator is entitled, to the extent permitted by law, to rely on all tables, valuations, certificates, opinions, and reports which are furnished by accountants, counsel, or other experts employed or engaged by the Plan Administrator.
6. **Expenses.** The proper expenses of the Plan Administrator, including the compensation of its agents, will be paid by the Plan if not paid by the Employer.

IV. ARTICLE - AMENDMENT AND TERMINATION

1. **Modification and Amendment.** The Plan may be modified or amended at any time by the Employer. Such modification or amendment shall be effective as of the date of the requisite Employer approval, or at such other date as the Employer shall designate.

The Welfare Programs may be modified or amended at any time by a proper officer of the Employer, provided that any Policy may only be modified or amended with the agreement of the issuing Insurance Company. Such modification or amendment shall be effective as of the date of the requisite approval, or at such other date as the Employer and, if applicable, Insurance Company shall designate.

2. **Termination.** The Plan and any underlying Welfare Program may be terminated at any time by the Employer. Such termination shall be binding on all Plan Participants.
3. **Conflict.** Any conflict arising between the terms of this Plan document and the terms of the Summary Plan Description with respect to the provisions of this Article shall be resolved in favor of this Plan document.

V. ARTICLE - CLAIMS PROCEDURES FOR PPACA EXEMPT PLANS

1. **General.** For purposes of determination of the amount of, and entitlement to, benefits of an insured Welfare Program provided under a Policy provided by an Insurance Company, the Insurance Company is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the Policy.

For purposes of determining the amount of, and entitlement to, benefits under a self-funded Welfare Program provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from an insured or self-funded Welfare Program, the Participant must follow the claims procedures prescribed under the applicable Welfare Program. ***In the event that (i) a self-funded Welfare Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or (ii) the Plan Administrator determines that the claims procedures described in a self-funded Welfare Program shall not apply, and (iii) a self-funded Welfare Program is not subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this Article shall apply with respect to such self-funded Welfare Program.*** If the self-funded Welfare Program is subject to PPACA, the claims procedure applicable to such self-funded Welfare Program is described in the Article titled: "Claims Procedures for Plans Subject to PPACA."

VI. ARTICLE - CLAIMS PROCEDURES FOR PLANS SUBJECT TO PPACA

1. **General.** For purposes of determination of the amount of, and entitlement to, benefits of an insured Welfare Program provided under a Policy provided by an Insurance Company Policy, the Insurance Company is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the Policy.

For purposes of determining the amount of, and entitlement to, benefits under a self-funded Welfare Program provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through the self-funded arrangement.

To obtain benefits from an insured or self-funded Welfare Program, the Participant must follow the claims procedures prescribed under the applicable Welfare Program. ***In the event that (i) a self-funded Welfare Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or (ii) the Plan Administrator determines that the claims procedures described in a self-funded Welfare Program shall not apply, and (iii) a self-funded Welfare Program is subject to PPACA, the claims procedure described in this Article shall apply with respect to such self-funded Welfare Program.*** If a self-funded Welfare Program is not subject to PPACA, the claims procedure applicable to such self-funded Welfare Program is described in the Article titled: "Claims Procedures for PPACA Exempt Plans."

VII. ARTICLE - QUALIFIED MEDICAL CHILD SUPPORT ORDERS

1. **Purposes.** The provisions of this Article shall apply with respect to any Welfare Program that does not contain provisions pertaining to QMCSOs (as defined below). The Plan Administrator, pursuant to Section 609(a) of ERISA, adopts the following procedures for determining whether medical child support orders are "qualified" in accordance with ERISA's requirements. The Plan Administrator also adopts these procedures to administer payments and other provisions under Qualified Medical Child Support Orders ("QMCSOs"), and to enforce these procedures as legally required. The Plan Administrator may alter, amend, or terminate these procedures and substitute alternative procedures in its sole discretion.
2. **Definitions.** For purposes of the QMCSO requirements, the following terms have these meanings:
 - a. **"Medical Child Support Order"** means any judgment, decree, or order (including approval of a settlement agreement) which:
 - i. Provides for child support for a child of a Participant under a group health plan, or provides for health coverage to such a child;
 - ii. Is made pursuant to state domestic relations law (including a community property law); and
 - iii. Relates to benefits under such group health plan.
 - b. **"Alternate Recipient"** means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Participant.
 - c. Any term used in this Article that is defined elsewhere in this Plan shall have the meaning assigned to such term under such other definition.
3. **Qualified Medical Child Support Order ("QMCSO").**
 - a. "Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order which creates or recognizes an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the group health portion of this Plan, and which the Plan Administrator has determined meets the requirements of this Section.
 - b. To be "qualified" as a QMCSO, a Medical Child Support Order must clearly:
 - i. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;
 - ii. Include a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined;
 - iii. Specify the period to which such order applies;
 - iv. Specify the Plan to which such order applies; and
 - v. Provide that the alternate recipient or parent of the alternate recipient will pay the applicable premium for family coverage under the Plan.

- c. In addition, a QMCSO must not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).
 - d. The alternate recipient's right to enroll in the Plan is dependent on the Participant's eligibility status in the Plan.
4. **Procedures.** Upon receipt of a Medical Child Support Order, the Plan Administrator shall:
- a. Promptly notify in writing the Participant, each alternate recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order.
 - b. Permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the Medical Child Support Order.
 - c. Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a Qualified Medical Child Support Order and notify the parties indicated in this Section of such determination.
 - d. Ensure the alternate recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the alternate recipient (and/or his or her representative) a copy of the summary plan description and any subsequent summaries of material modification generated by a Plan amendment.

VIII. ARTICLE - GENERAL PROVISIONS

1. **COBRA Rights.** With respect to each Welfare Program which is a group health plan within the meaning of Section 601 of ERISA, each Participant and his or her family members may have the right to purchase continuous coverage for a temporary period of time if coverage under the group health plan terminates due to certain COBRA qualifying events (such as termination of employment, reduction in work hours, divorce, death, or a child ceasing to meet the definition of dependent under the terms of the group health plan). In general, a Participant or family member must elect COBRA continuation coverage within 60 days following the date of the qualifying event, or if later, the date notice of the qualifying event is provided to the individual. If continuation coverage is elected, the individual will be responsible for paying the full cost of continuation coverage plus an administrative fee.
2. **Newborns' and Mothers' Health Protection Act.** With respect to each Welfare Program that is a group health plan providing maternity benefits, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than the above periods. In any case, such group health plan will not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.
3. **Women's Health and Cancer Rights Act ("WHCRA").** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
 - a. All stages of reconstruction of the breast upon which the mastectomy was performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - c. Prostheses; and
 - d. Treatment of physical complications during all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under this Plan.
4. **Family and Medical Leave Act ("FMLA").** The Employer will maintain benefits under each Welfare Program that is a group health plan for an Employee on FMLA leave on the same terms and conditions as if the Employee had continued to work. If an Employee returns from FMLA leave and chose not to retain group health plan coverage during the leave, the Employer will reinstate the Employee in such group health plan coverage on the same terms as prior to the leave.
5. **Uniformed Services Employment and Reemployment Rights Act ("USERRA").** Except to the extent greater benefits are provided under a Welfare Program, a Participant who is performing service in the uniformed services and is covered under the Plan is entitled to continue coverage for himself or herself and dependents if applicable, provided the Participant elects to continue coverage for the lesser of the following periods:
 - a. The 24-month period beginning on the date the Participant's absence for the purpose of performing service begins; or
 - b. The period beginning on the date the Participant's absence for the purpose of performing service begins and ending on the date which the Participant fails to return from service or apply for a position of employment as provided in USERRA or the regulations thereunder.

COBRA continuation coverage provided under the Sections titled: "COBRA Rights" and "USERRA" under this Article are concurrent.

6. **Governing Law.** This Plan shall be governed and construed in accordance with the internal laws of the State of Washington without giving effect to any choice of law or conflict of law provision or rule (whether the State of Washington or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of Washington. Notwithstanding the foregoing, in the event that the laws of the State of Washington are superseded by the Internal Revenue Code of 1986, as amended (the "Code") and/or ERISA, the Code and/or ERISA shall control.
7. **Situs.** The situs of the Plan is in King County, Washington. Any legal claims brought against the Plan, the Plan Administrator, or the Employer with respect to any and all matters pertaining to the Plan must be brought in federal court in King County, Washington.
8. **Claims Deadline.** Unless specifically provided otherwise in a Policy or Welfare Program document or pursuant to applicable law, a claim for benefits under this Plan (including the component Welfare Programs) must be made within one (1) year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the claimant, or his or her designee, to ensure this requirement is met.
9. **Limitation Period for Filing Suit.** Unless specifically provided otherwise in a Policy or Welfare Program document or pursuant to applicable law, a suit for benefits under this Plan must be filed with the appropriate court, after exhausting administrative remedies, within two (2) years from the accrual of the cause of action.
10. **Construction of Plan Document.** The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge, or describe the scope or intent of the Plan, nor in any way affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.
11. **Coordination of Benefits.** If a covered person under the Plan is eligible for benefits under more than one group health plan, the benefits available under the Plan will be coordinated in the manner described in the applicable Policy or Welfare Program document.
12. **Severability Clause.** In case any provision of this Plan shall be held unlawful or invalid for any reason, such unlawfulness or invalidity shall not affect the remaining parts of this Plan, and this Plan shall be construed and enforced as if such unlawful or invalid provisions had never been inserted herein.
13. **Plan in Effect at Termination of Employment Controls.** Unless expressly indicated otherwise, no provision of this Plan shall apply to any Employee who terminated employment prior to the effective date of such provision. In addition, unless expressly indicated otherwise, any amendment to this Plan shall not apply to any Eligible Employee who terminates employment prior to the effective date of such amendment.
14. **No Guarantee of Employment.** This Plan shall not be deemed to constitute a contract between the Employer and any Eligible Employee or Participant, or to be consideration or an inducement for the employment of any Participant or Eligible Employee. Nothing contained in this Plan shall be deemed to give any Participant or Eligible Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Eligible Employee at any time, regardless of the effect which such discharge shall have upon such Eligible Employee as a Participant in the Plan.

- 15. Non-Alienation of Benefits.** No benefit, right or interest of any Participant or beneficiary under the Plan shall be subject to anticipation, alienation, sale, assignment, transfer, process, or be liable for, or subject to, the debts, liabilities, or other obligations of such person, and no such attempted or purported anticipation, etc., will be recognized by the Plan, except as otherwise required by law. Nothing in this clause will prevent the Plan Administrator from paying a provider or similar entity directly and any such payment shall not constitute a waiver of this anti-assignment clause.
- 16. Limitation of Rights.** Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed so as to give any person any legal or equitable right against the Employer, except as expressly provided herein or required by law.
- 17. Cooperation.** Circumstances may arise in which the Employer or the Plan Administrator may require a Participant or beneficiary to furnish information or pay an amount that directly or indirectly relates to participation in, or benefits paid or payable from a Welfare Program. Each Participant or beneficiary, in consideration of the coverage provided by such Welfare Program, must fully cooperate and provide any and all information requested, execute any and all documents that will enable the Employer or the Plan Administrator to access such information, and pay any amount due pursuant to the Welfare Program. In the event a Participant or beneficiary fails to comply with this cooperation provision within the time period set by the Plan Sponsor in its sole and absolute discretion or provides false information in response to such request, payment of all benefits under the Welfare Program (whether or not such benefits relate to the requested information or failure to pay) may be suspended and/or coverage may be terminated either retroactively or prospectively in the Employers sole discretion and in compliance with applicable law. In addition, the Employer or the Plan Administrator may pursue any other remedy available to it, including obtaining an injunction to require cooperation, or recovering from the covered person or beneficiary damages for any loss incurred by it as a result of the failure to cooperate or make payment, or the provision of false information.
- 18. Overpayments.** If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a covered person, the covered person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the Employer (or its designee), or the applicable Insurance Company may recover that incorrect payment, whether or not it resulted from the Insurance Company's, or Plan Administrator's, Employer's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable Insurance Company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.
- 19. Mental Health Parity and Addiction Equity Act.** Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712 (where applicable).
- 20. Genetic Information Nondiscrimination Act ("GINA").** Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.
- 21. Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP").** The Plan will comply with the "group health plan" requirements relating to CHIP under the Children's Health Insurance Program Reauthorization Act of 2009.

IX. ARTICLE - PLAN PRIVACY RULES

1. **Introduction.** The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") mandates strict privacy and security standards to protect Protected Health Information ("PHI") as defined below. In addition, the Plan will ensure that PHI that is Electronic Protected Health Information ("ePHI") pertaining to covered persons remains confidential to the extent required under HIPAA. This Article sets forth the guidelines the Plan Sponsor must follow when using and disclosing PHI.
2. **Definitions.**
 - a. **"Individually Identifiable Health information"** means health information that either actually identifies an individual or creates a reasonable basis to believe that the information would identify the individual.
 - b. **"Protected Health Information"** or "PHI" means health information that:
 - i. Is created or received by health care providers, health plans, or health care clearinghouses;
 - ii. Relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and
 - iii. identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.
 - c. **"Electronic Protected Health Information"** or "ePHI" is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.
 - d. **"Plan Sponsor"** means the Employer.
3. **Permitted Uses and Disclosures.** The Plan Sponsor can use or disclose PHI without prior Participant authorization or consent in the following situations:
 - a. When the PHI is used or disclosed to the Participant who is the subject of the PHI;
 - b. When the PHI is used or disclosed for treatment, payment, or health care operations;
 - c. When the PHI is used or disclosed incident to a use or disclosure otherwise permitted or required under the privacy rules set forth in this Article, and such disclosure occurs despite reasonable Plan safeguards which are in place;
 - d. When the PHI is used or disclosed pursuant to and in compliance with a valid authorization; and
 - e. When the PHI is used or disclosed pursuant to an agreement with the Participant in situations where the Participant is given the choice to agree to or object to such use or disclosure.
4. **Required Uses and Disclosures.** The Plan Sponsor must disclose PHI in the following situations:
 - a. When Participants request access to their own PHI, or request an accounting of the Plan's disclosures of their own PHI; and
 - b. When required by the U.S. Department of Health and Human Services to determine the Plan's compliance with the privacy rules set forth in this Article.

5. Certifications. The Plan Sponsor certifies and agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan or applicable law;
- b. Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- c. Not use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan;
- d. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by the Plan and of which the Plan Sponsor becomes aware;
- e. Make a Participant's PHI available to such Participant;
- f. Allow a Participant to amend his or her PHI;
- g. Make an accounting of disclosures of PHI available to a Participant;
- h. Make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance;
- i. If feasible, return or destroy all PHI received from the Plan that it still maintains and that is no longer needed for the purpose for which the disclosure was made; if destruction is not possible, limit further uses and disclosures; and
- j. Ensure adequate separation between the Plan and the Plan Sponsor.

6. Obligations with Respect to ePHI Obtained from the Plan. As a condition of receiving ePHI from the Plan for Plan administrative functions, the Plan Sponsor specifically agrees to:

- a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- b. Ensure that the adequate separation, between the Plan Sponsor and persons who have no legitimate need to access such PHI, as required by 45 CFR. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
- c. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect ePHI; and
- d. Report to the Plan any security incident of which it becomes aware.

7. Adequate Separation Between the Plan and the Plan Sponsor.

- a. **Access to PHI.** The following employees of the Plan Sponsor (and any successors to their current job titles/positions) may be given access to PHI because such access is essential for them to perform their Plan administration duties:
 - i. Senior Benefits Manager
 - ii. Benefits Analyst
 - iii. Director of Total Rewards

- b. **Restricted Access.** The employees listed in (a) above shall have access to PHI that is restricted to Plan administration functions necessary and essential for the ongoing functioning of the Plan.
 - c. **Procedures for Resolving Noncompliance.** The Plan's Privacy Officer has responsibility for facilitating and ensuring compliance with all privacy rules and procedures. All employees and contractors of the Plan Sponsor who handle PHI will be subject to enforcement sanctions administered in a manner that is consistent with the Plan Sponsor's human resources policies and procedures. Sanctions will be determined based on the nature of the violation, its severity, whether or not the violation was intentional, and whether or not the offending individual has engaged in previous violations. Sanctions may include verbal warnings, written warnings, probationary periods, suspension, or termination. Sanctions will be consistently applied in a nondiscriminatory manner.
8. **Interpretation.** Any ambiguity regarding controlling provisions shall be resolved in favor of an interpretation that permits the Plan to comply with HIPAA and other federal and state laws and that provides the greatest privacy protections for Protected Health Information. In the event of an inconsistency between the provisions of this Plan and mandatory provisions of HIPAA, the HIPAA provisions shall control.

X. ARTICLE - PATIENT PROTECTION AND AFFORDABLE CARE ACT COMPLIANCE

1. **Pre-Existing Conditions.** Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre- existing conditions for individuals.
2. **Lifetime/Annual Limits.** Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under the group health plan. "Essential benefits" shall be those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.
3. **Cost Sharing Requirements for Preventive Care Expenses.** With regard to non- grandfathered benefits under the Plan, there shall be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.
4. **Dependent Definition.** The term "Dependent" shall include any child of a participant who is covered under an insurance contract, as defined in the contract, or under a self-funded plan, as defined in the plan, subject to PPACA and the regulations and guidance issued thereunder.
5. **No Rescission of Coverage.** The Plan shall not rescind coverage except in the case of fraud, divorce or an intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.
6. **Selection of Providers.** If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the Participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.
7. **Emergency Services.** With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out-of-network) and without regard to whether the health care provider furnishing the emergency services is an in- network provider with respect to the services.
8. **Cost Sharing Limits.** With respect to non-grandfathered benefits under the Plan, this Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed for high deductible health plans. For 2019, these limits are \$7,900 for an individual and \$15,800 for family coverage. In 2020, these limits will be \$8,150 for an individual and \$16,300 for family coverage. After 2020, these amounts will be adjusted for health insurance premium inflation. For these purposes, if the Plan utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums, the Plan will combine the annual limitation on out-of-pocket maximums for each other type of plan coverage (e.g., prescription drug coverage) on an aggregate basis.
9. **Clinical Trials.** With respect to non-grandfathered benefits under the Plan, this Plan shall not deny any "qualified individual," as set forth in Public Health Service Act §2709, participation in an

approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This Plan also shall not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, this Plan shall not discriminate against the individual on the basis of the individual's participation in such trial.

10. Provider Discrimination. With respect to non-grandfathered benefits under the Plan, this Plan shall not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under applicable state law, as required by Public Health Service Act §2706(a).

11. Applicability. This Article shall apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.

APPENDIX A

Welfare Program	Insurance Company or Third-Party Administrator	Policy or Contract Number	PPACA Applicability
Medical/Rx and Vision (Self-Funded) Premera Blue Cross Effective Date: 10/01/2017	Premera Blue Cross 7001 220th St. SW, Building 1 Mountlake Terrace, WA 98043	1038715	Applicable
Dental (Self-Funded) Delta Dental of Washington Effective Date: 10/01/2017	Delta Dental of Washington 400 Fairview Ave N, #800 Seattle, WA 98109	9305	Applicable
Life/AD&D and Disability Sun Life Assurance Co. of Canada Effective Date: 10/01/2017	Sun Life Financial SC 2350 Wellesley Hills, MA 02481	223799	Not Applicable
Flexible Spending Account (FSA) Navia Benefit Solutions Effective Date: 10/01/2017	Navia Benefit Solutions 600 Naches Ave SW Renton, WA 98057	No Policy Number	Applicable
Employee Assistance Program	ComPsych (Sun Life) 455 N. City Front Plaza Dr. Chicago, IL 60611	No Policy Number	Applicable

Execution Agreement

IN WITNESS WHEREOF, F5 Networks, Inc. has caused its authorized officer to execute this Plan document as of 9/10/19, the same to be effective October 1, 2019, unless otherwise indicated herein.

F5 Networks, Inc.

By:

Ana White

Name:

Ana White

Title:

EVP & CHRO

CERTIFICATE OF RESOLUTION

The governing body of F5 Networks, Inc. (the Employer) has delegated the authority to adopt the following resolutions on its behalf to the undersigned authorized representative. With her signature, such authorized representative hereby certifies that the following resolutions were duly adopted on behalf of the Employer and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of Welfare Benefit Plan, effective October 1, 2019, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the undersigned representative is hereby authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the Plan.

RESOLVED, that the proper agents of the Employer shall act as soon as possible to notify the Employees of the Employer of the adoption of the Plan and to deliver to each Employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approved.

The undersigned further certifies that attached hereto as Exhibits, are true copies of F5 Networks, Inc.'s Benefit Plan Document and Summary Plan Description approved and adopted at this meeting.

F5 Networks, Inc.

By:

Ana White

Name:

Ana White

Title:

EVP + CHRO