

F5 Networks, Inc.

801 5th Avenue Seattle, WA 98104

F5 Networks, Inc. Employee Benefit Plan

Summary Plan Description

Effective October 1, 2019

TABLE OF CONTENTS

I. Summary Plan Description and General Information

II. Summary of Plan Benefits

III. Claims Procedure for PPACA Exempt Plans

IV. Claims Procedure for Plans Subject to PPACA

V. When Coverage May Be Continued

VI. Qualified Medical Child Support Order

VII. PPACA compliance

VIII. ERISA Rights

I. SUMMARY PLAN DESCRIPTION SUPPLEMENT

This document and the certificates issued with respect to the Welfare Programs described herein (the “Policy” or “Policies”) together comprise the Summary Plan Description (SPD) for the F5 Networks, Inc. Employee Benefit Plan (the “Plan”). If the terms of this document conflict with the terms of the Certificates, then the terms of the Certificates will control, unless otherwise required by applicable law. In the event of a conflict between the terms of the SPD and the terms of the Plan Document, the Plan Document will control, unless otherwise required by applicable law.

The SPD summarizes your rights and obligations as a participant (or beneficiary) in the Plan. It is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded to you by the Plan or any applicable state law not pre-empted by ERISA, those legal rights supersede the rights set forth in the SPD.

GENERAL INFORMATION

NAME OF PLAN:

F5 Networks, Inc. Employee Benefit Plan

EMPLOYER:

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

The Employer is sometimes referred to as the ***“Plan Sponsor” or “Company.”***

EMPLOYER IDENTIFICATION NUMBER:

91-1714307

PLAN NUMBER:

505

PLAN ADMINISTRATOR:

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

TYPE OF PLAN:

F5 Networks, Inc. Employee Benefit Plan including Medical/Rx, Dental, Life, AD&D, STD, LTD, and Health Care and Day Care FSA benefits.

PLAN YEAR:

Other than any applicable short plan year, the Plan’s records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan Year begins on October 1 and ends on September 30.

CLAIMS ADMINISTRATION:

Claims for benefits are administered by the respective companies set forth at Appendix A that include but are not limited to: Medical/Rx, Dental, Life, AD&D, STD, LTD, and Health Care and Day Care FSA.

CLAIMS ADMINISTRATION:

Unless specifically provided otherwise in a Policy or Welfare Program document, you must submit a claim for benefits to the Plan within one (1) year after the date that you incur the expense that gives rise to the claim. It is your responsibility (or that of your designee) to ensure that you meet this requirement.

LIMITATION PERIOD FOR FILING SUIT:

Unless specifically provided otherwise in a Policy or Welfare Program document, if you wish to bring a legal claim against the Plan in a court of law (after exhausting the Plan's internal claims and appeals procedure), you must file it within two (2) years after the claim has accrued.

AGENT FOR SERVICE OF LEGAL PROCESS:

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

You may also serve legal process on the Plan Administrator or any successor in title or office of the current registered agent of the Company.

TYPE OF ADMINISTRATION:

Some benefits under the Plan are fully insured and are paid pursuant to the terms of Policies issued by insurance companies.

Other benefits are self-funded and are paid from the general assets of the Employer. The Employer has entered into contracts with third party vendors to assist the Employer in administering self-funded benefits.

ELIGIBILITY:

The eligibility and participation requirements for each Welfare Program are stated in the applicable Policy or Welfare Program document. Where the eligibility and/or participation requirements are not stated in the Policy or Welfare Program document, the eligibility and/or participation requirements stated in this SPD and the Plan Document shall control, as otherwise set forth below:

	Benefits	
	Medical and Dental	Life, AD&D, STD, LTD, Health Care and Day Care FSAs
Eligible Employees		
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 if the Eligible Employee is applying for optional life insurance for themselves and a spouse or domestic partner; 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 the Eligible Employee's initial eligibility date, the election requiring such documents will be canceled.

Other individuals, such as Eligible Employee's spouse (spouse shall also mean "domestic partner"), 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.

A reemployed former Participant shall again be eligible to become a Participant in the Plan when the Participant again satisfies the requirements set forth in the Section titled: "Eligibility and Participation."

AMENDMENT AND TERMINATION:

The F5 Networks, Inc. Employee Benefit Plan (the "Plan Document") contains all the terms of the Plan and may be amended, modified, or terminated from time to time at the sole discretion of your Employer. Any changes made shall be binding on each Covered Participant and any other Covered Persons referred to in the Plan Document.

The underlying Policies and Welfare Program documents will disclose any Plan provisions governing your benefits, rights, and obligations upon plan termination or the amendment or elimination of benefits under the Plan.

NO CONTRACT OF EMPLOYMENT:

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the companies listed below to the effect that you will be employed for any specific period of time.

BENEFITS AND ADMINISTRATION:

The Plan provides benefits for eligible employees and covered dependents as administered under Policies of insurance as listed in Appendix A that include but are not limited to: Medical/Rx, Dental, Life, AD&D, STD, LTD, and Health Care and Day Care FSA. These Welfare Programs are insured or administered by the companies also listed in Appendix A and are generally described in the Plan Document. The administrative functions include paying claims and determining medical necessity.

Replacements for lost or misplaced copies of the Plan Document may be obtained by writing to the Plan Administrator. Notification will be given of changes in benefits that may occur from time to time.

Please refer to the Plan Document for a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits.

II. SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible dependents with the coverages summarized in Appendix A. A summary of the benefits provided under the Plan is set forth in the Policies issued by the insurance companies.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

WOMEN'S HEALTH 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.

LOSS OF BENEFITS:

The provisions regarding termination of coverage and limitations and exclusions of benefits that may result in reduction or loss of benefits are explained in the underlying Policies and Welfare Program documents.

CONTRIBUTIONS:

Contributions to the Plan are provided by the Employer and Employees. Employee contributions are made via automatic payroll deductions. The Plan Administrator will provide a schedule of the applicable premiums during open enrollment periods and upon request.

HOW TO RECEIVE YOUR BENEFITS:

This information is explained in the article entitled "CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS" or "CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA" as the case may be.

BENEFIT-SPECIFIC INFORMATION:

Please refer to the appropriate insurance Policies and/or summaries of coverage for the following information:

- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which you or a beneficiary will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventative services are covered under the Plan;
- Whether, and under what circumstances, existing and new drugs are covered under the Plan;
- Whether, and under what circumstances, coverage is provided for medical tests, devices, and procedures;
- Provisions governing the use of network providers;
- The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service under the Plan.

III. CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. Please refer to the claims procedure set forth in the applicable Policy or Welfare Program document for details regarding that Welfare Program's claims procedure. *To the extent that a claims procedure is not prescribed for a self-funded Welfare Program, and the self-funded Welfare Program is not subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section 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 section entitled "Claims Procedure for Plans Subject to PPACA."

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

IV. CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. Please refer to the claims procedure set forth in the applicable Policy or Welfare Program document for details regarding that Welfare Program's claims procedure. *To the extent that a claims procedure is not prescribed for a Welfare Program, and the Welfare Program is subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such Welfare Program.* If the Welfare Program is not subject to PPACA, the claims procedure applicable to such Welfare Program is described in the section entitled "Claims Procedure for PPACA Exempt Plans."

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent, and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

V. WHEN COVERAGE MAY BE CONTINUED

You and your covered dependents may continue your medical coverage under this Plan under certain circumstances, according to the terms of your employer's Leave of Absence Policy, the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA). Medical coverage for yourself and your covered dependents may be continued if you cease active work because of an approved medical, family, personal, or military leave of absence, or if your employment ends.

COBRA CONTINUATION OPTIONS:

To the extent a description of COBRA rights is not provided for a Welfare Program, the following applies:

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Are there other coverage options?

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (the "Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Please note that certain excepted benefits such as health flexible spending accounts, integrated health reimbursement arrangements, or standalone vision or dental plans will not be offered under the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- a. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a Covered Employee, the spouse of a Covered Employee, or a dependent child of a Covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- b. Any child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "Covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility for these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a Covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding sentence, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- a. The death of a Covered Employee.
- b. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Covered Employee's employment.
- c. The divorce or legal separation of a Covered Employee from the Employee's spouse. If the Employee reduces or eliminates their spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
- d. A Covered Employee's enrollment in any part of the Medicare program.
- e. A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the Covered Employee, or the covered spouse or a dependent child of the Covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee, or the spouse, or a dependent child of the Covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event may occur, however, if an Employee does not return to

employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

Premiums. This Plan can charge up to 102% of the total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Enrolling in another Group Health Plan. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA vs. Marketplace. Other factors to consider when weighing your coverage options include: premium costs, whether a change in coverage will affect your access to certain providers, service areas, or drug formularies and whether the coverage change will affect your cost sharing (i.e., new deductibles, etc.). See the discussion above under "Are there other coverage options?" for more information on your options for Marketplace coverage.

What is the election period and how long must it last?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period. The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his or her right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a Covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for the Employee and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its

designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- a. the end of employment or reduction of hours of employment,
- b. death of the Employee,
- c. commencement of a proceeding in bankruptcy with respect to the Employer, or
- d. the Employee's entitlement to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (e.g., divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing or submitted in Workday within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

1. Written Notice:

Any notice that you provide must be *in writing*. An oral notice, including notice by telephone, is not acceptable. You must email, mail, fax, or hand-deliver your notice to the following:

F5's Benefits Team
F5 Network, Inc.
801 5th Avenue
Seattle, WA 98104
FAX: 206-272-6925
Email: benefits@f5.com

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the Employee covered under the plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

2. Workday Notice:

A change in Workday (<https://federate.f5.com/Workday>) would be considered written notice of a Qualifying Event if it has been submitted on or before the end of 60-day notice period.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has

occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their dependent children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- a. The last day of the applicable maximum coverage period.
- b. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- c. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
- d. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.
- e. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- f. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - i. 29 months after the date of the Qualifying Event or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

- ii. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- a. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- b. In the case of a Covered Employee's entitlement to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of:
 - c. 36 months after the date the Covered Employee becomes entitled to Medicare; or
 - d. 18 months (or 29 months, if there is a disability extension) after the date of the Covered Employee's termination of employment or reduction of hours of employment.
- e. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- f. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18-month or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the Covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours

of a Covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator or its designee will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan or its designee at a later date is also considered Timely Payment if either (i) under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed to make the payment until that later date, or (ii) under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed to pay for coverage of similarly situated non COBRA beneficiaries for the period in question until that later date.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan or its designee.

If Timely Payment is made to the Plan or its designee in an amount that is not significantly less than the amount the Plan requires to be paid, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan or its designee notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. You should be aware that if you do not pay a premium by the first day of a period of coverage, but pay the premium within the grace period for that period of coverage, the Plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Failure to make payment in full before the end of a grace period could cause you to lose all COBRA rights.

Who can I contact for more information?

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health

Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

FAMILY AND MEDICAL LEAVE ACT (“FMLA”):

Except to the extent otherwise provided in the appropriate insurance Policies and/or summaries of coverage, the provisions provided in this document with respect to the Family and Medical Leave Act of 1993 (“FMLA”) will apply. If you meet certain service requirements, you may be entitled to take a maximum of 12 weeks of unpaid leave each year for certain specified family and medical reasons under the FMLA. Upon your return to work after FMLA leave, you will be entitled to the position that you held when your FMLA leave began or an equivalent position with equivalent pay, benefits and other terms and conditions of employment.

Under certain circumstances, when restoration of employment would cause substantial and grievous economic injury to the Employer’s operations, certain highly paid “key” employees may not be reinstated after FMLA leave.

You must notify your Employer at least 30 days before the beginning of your leave if the leave is foreseeable. If the leave is not foreseeable, you must provide such notification as soon as possible. Please contact the Employer to determine whether you qualify for FMLA leave.

If you take leave under FMLA, you will be entitled during your leave to continue your benefits at the same coverage level in effect at the time of your leave. If you marry or have or adopt a child (or you otherwise acquire a new dependent) during your leave, your new spouse or dependent will also be eligible for coverage during your leave (if you continued your coverage under the Plan and such spouse or dependent meets the Plan’s eligibility requirements). You may be responsible for paying your portion of these benefits at active employee rates while you are on leave, paying your contributions on a monthly basis (with after-tax dollars) in the manner required by the Employer. Please contact your Employer for more information.

You will be eligible for new benefits that are offered by the Employer during your leave. Your coverage will also be affected by any changes that the Employer makes to the benefit plans and programs during your leave. If the costs for providing new or changed benefits increase during your leave, your contributions may increase accordingly.

When you return from your FMLA leave, you will continue your benefits in accordance with your coverage elections that were in effect immediately before your leave. You will be able to make coverage elections that differ from those that were in effect before your leave only if there is an annual open enrollment period at that time or you have a qualifying event.

FMLA and leave to care for a service member

If you need to care for a family member who was injured or became ill while on active military duty, you may be entitled to up to 26 weeks of FMLA leave. Additionally, unpaid active duty leave may also be available. Any leave related to military duty or military illness or injury will be administered in accordance with applicable federal requirements.

1. Military Caregiver Leave

Military caregiver leave, which is unpaid, will be granted to you in the event that you are needed to care for a family member who is an Armed Forces service member recovering from a serious illness or injury. If you are the spouse, son, daughter, parent, or nearest blood relative of a service member who is medically unfit to perform the duties of his or her office, grade, rank or rating, and the service member is undergoing medical treatment, recuperation, or therapy, is in an outpatient status, or is on the temporary disability retired list, you may take job-protected leave in order to care for the service member.

Military caregiver leave will not be provided in addition to FMLA leave taken for other reasons, and the 26-week military caregiver leave may only be taken in a single 12-month period.

2. Active Duty Leave

If you are eligible for FMLA leave, active duty unpaid leave (when required by the government) will be granted if a family member has been called up to or engaged in active military duty. Under the active duty leave provision, the Employer will grant up to 12 weeks of FMLA leave. This leave will be granted for events outlined in regulations, and the leave will be available if your spouse, son, daughter, or parent is on or is called into active duty against another military force. If you request this leave you must provide the Employer with notice as soon as it is “reasonable and practicable” and you may be required to provide certification supporting the active duty of the affected family member.

If you have any questions regarding whether FMLA leave applies to you, you should contact F5’s Benefit Team.

CONTINUATION OF COVERAGE UNDER USERRA:

The Uniformed Services Employment and Reemployment Rights Act (“USERRA”) provides for continuation of health care coverage for employees called for active duty military service.

Except to the extent greater benefits are provided under the terms of the appropriate insurance policies and/or summaries of coverage, the maximum length of extended coverage under USERRA is the lesser of:

- a. 24 months beginning on the date that the military leave begins; or
- b. A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

COBRA continuation coverage and USERRA continuation coverage are concurrent.

VI. QUALIFIED MEDICAL CHILD SUPPORT ORDER (“QMCSO”)

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree, or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. A QMCSO may apply to coverage under the Plan. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are assigned pursuant to the order.

VII. PATIENT PROTECTION AND AFFORDABLE CARE ACT (“PPACA”) COMPLIANCE

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.

Lifetime/Annual Limits. Notwithstanding anything contained in the Plan to the contrary, the 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” are those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

Cost Sharing Requirements for Preventive Care Expenses. With regard to non- grandfathered benefits under the Plan, there will 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.

Dependent Definition. The term “Dependent” includes 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, to the extent allowed by PPACA and the regulations and guidance issued thereunder.

No Rescission of Coverage. The Plan will 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.

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.

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.

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. In 2017, these limits are \$7,150 for an individual and \$14,300 for family coverage. After 2017, 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 for Essential Health Benefits of a group health plan, the Plan will combine with the annual limitation on out-of-pocket maximums between each provider as an aggregate benefit limit amount.

Clinical Trials. With respect to non-grandfathered benefits under the Plan, this Plan will 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 will 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 will not discriminate against the individual on the basis of the individual's participation in such trial.

Provider Discrimination. With respect to non-grandfathered benefits under the Plan, this Plan will 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).

Applicability. This section will 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.

VIII. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”) RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

Receive a summary of the Plan’s annual financial report, if any is required by ERISA to be prepared, in which case, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD Supplement and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified

status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or organization you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees--for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A

SUMMARY OF BENEFIT OPTIONS AND PROVIDER CONTACTS

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

IMPORTANT NOTICE FROM F5 NETWORKS, INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Individual Creditable Coverage Disclosure Notice

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with F5 Networks, Inc. (the "Company") in the F5 Networks, Inc. Employee Benefit Plan (the "Plan") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Company has been informed that the prescription drug coverage offered by the Plan is, on average for all Plan Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered "Creditable Coverage." Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period ("SEP") to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage may be affected. If you opt to purchase a Medicare drug plan, the coverage under the drug Plan may no longer be available. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact your Plan Administrator if you have further questions.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan and don't join a Medicare drug plan within 62 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage, Contact the Employer for Further Information at:

F5's Benefits Team
F5 Networks, Inc.
801 5th Avenue
Seattle, WA 98104
206-272-5555
benefits@f5.com

NOTE: You will receive this notice annually. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1- 800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:	F5 Networks, Inc.
Contact / Attention	F5's Benefits Team
Address	801 5 th Avenue, Seattle, WA 98104
Phone Number	206-272-5555
Date	October 1, 2019

EMPLOYER REQUIREMENTS FOR MEDICARE MODERNIZATION ACT

1. Must identify who is Medicare Eligible Individual, including their dependents:
 - Active Medicare eligible Employees or their Medicare eligible dependents
 - Medicare eligible Cobra Participant, or their Medicare eligible dependents
 - Medicare eligible Disabled Individual covered under the Rx Plan
 - Medicare eligible Retirees or their dependents who are covered under the Rx Plan
2. Determine if Group Health Plan or Rx benefit is "Creditable."
3. Provide the disclosure notices to Medicare Eligible individuals (as noted above), at minimum
 - Prior to an individual's initial enrollment period for Medicare Rx drug benefit;
 - Prior to the effective date of enrolling in the sponsors plan and upon any change that affects whether coverage is a creditable Rx benefit;
 - Prior to the commencement of annual election period that begins on 10/15 of each year; and
 - Upon beneficiary request.
4. Complete Online Questionnaire (link below) within 60 days of the beginning of the Plan year or within 30 days of a plan termination or change.

<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html>

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by the Company's group health Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan Sponsor, we often need access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan Sponsor, we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we may charge you \$0.05 (5 cents) for each

page. Your request to inspect or review your health information must be submitted in writing to F5's Benefits Team, listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within our records is incorrect or missing, you have a right to request that we correct the incorrect or missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact F5's Benefits Team, listed below.

Legal Information

The Company is required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our privacy practices, contact F5's Benefits Team, listed below:

F5's Benefits Team
F5 Networks, Inc.
801 5th Avenue
Seattle, WA 98104

If you have any questions or complaints, please contact the Plan Administrator listed under the Article titled: "General Information About Our Plan."

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact F5's Benefits Team, listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. F5's Benefits Team, listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.

EMPLOYER REQUIREMENTS FOR DISTRIBUTING ERISA DOCUMENTS

The Plan Administrator/Employer is responsible for preparing the Summary Plan Description ("SPD") and **AFFIRMATIVELY DELIVERING** it to certain persons:

- Covered Employees
- Terminated Cobra Participants
- Parents or guardians of children covered under a qualified medical support order
- Dependents of a deceased participant
- Guardians of an incapacitated person

An employer should be prepared to prove it furnished the SPD in a way "reasonably calculated to ensure actual receipt" using a method "likely to result in full distribution." I.E., first class mail, hand-delivery, and electronically, if the employees have access to computers in the workplace and can print a copy easily.

Electronic Distribution of ERISA Documents

Employees with work-related computer access

The employee has the ability to access documents at any location where they perform employment duties. Access to Employer's electronic information system must be an integral part of their normal duties.

- Electronic materials prepared and furnished in accordance with applicable requirements
- Notice is provided to each recipient when furnished, detailing the document
- Notice advises participant of their rights to access the document and how to request a paper copy
- Employer must take steps to ensure the electronic transmittal will result in actual receipt
- If disclosure includes PHI, steps are taken to safeguard the confidentiality of the information

Requirements for Employees with Non-work-related computer access or non-employees

May include COBRA participants, dependents, or disabled participants.

- Affirmative consent required; **pre-consent** must be obtained, which include details of types of document to be provided, right to withdraw consent, including procedures and updating of information (new email), right to request a paper version and if any cost, and the hardware and software requirements to access the electronic document.
- Pre-Consent statement can be sent electronically if have a reliable e-mail address
- If system hardware or software requirements change, a revised statement must be provided and consent from each individual must be obtained.
- If documents provided on internet, **consent** must be given in a manner that illustrates the individual's ability to access the information along with a current email address.
- Employer must keep track of individual email addresses for delivery, the consents and actual receipt of emailed documents by recipients.
- These requirements along with the five steps outlined above for Employees with work-related computer access.

ERISA Required Documents for Participants

- SPD - Summary Plan Description
- Restatement of SPD due to Plan Modifications
- SBC - Summary of Benefits and Coverage
- SAR - Summary Annual Report
- Plan Documents
- Other Group Health Plan Notices

DOCUMENT

DISTRIBUTION INSTRUCTIONS

SPD

To Participants within 90 days of coverage on existing plan; within 120 days for new plan. Every 5 years if plan amended or every 10 years if no changes made

Restatement of SPD

To Participants no later than 210 days after end of the plan year in which change is adopted.

SBC

To participants with enrollment materials, at renewal or reissue of coverage. Special enrollees no later than 90 days from enrollment. Otherwise, within 7 days of written request.

SAR

To participants within 9 months after plan year end if Employer is required to file Form 5500 for the benefit plan

Plan Document

Copies must be furnished no later than 30 days after written request.

There are notices required under other provisions in ERISA (i.e., the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Newborns' and Mothers' Health Protection Act (Newborns' Act), and the Women's Health and Cancer Rights Act (WHCRA)). Some of these notices may be included in the SPD and others must be provided separately due to the timeframes for when they are required to be provided.

Please be sure to check for current laws and regulations on the reporting and disclosure provisions included in the publication on EBSA's Website at <http://dol.gov/ebsa>.