Fortinet, Inc. Health and Welfare Plan and

Master Summary Plan Description

Amended Effective January 1, 2025

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

This Wrap Summary Plan Document (SPD) has been formally modified through the Summary of Material Modification document(s) attached at the back of this document.

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1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended.

"Claims Administrator" means the insurer or any third party engaged by the Plan Administrator to determine benefit claims under the benefit programs, or if none has been engaged the Plan Administrator. Contract information for the Claims Administrator can be found in Section 14.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Company" means Fortinet, Inc., or any successor thereto.

"DCAP" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work.

"Employee" means any common-law employee of the Company who resides in the United States, satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except employees classified or treated by the Company as independent contractors, temporary employees or as an employee of an employment agency, even if such person is later reclassified by a Court or governmental agency as a common-law employee of the Company.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Health FSA" means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

"GINA" means the Genetic Information Nondiscrimination Act of 2008, as amended.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"MHPA" means the Mental Health Parity Act of 1996, as amended.

"MHPAEA" means the Mental Health Parity and Addiction Equity Act of 2008, as amended.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means the Company Welfare Benefits Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 14.

"Plan Administrator" means the Company.

"SPD" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 14. See Section 14 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). The Benefit Descriptions can also be found at Fortinet.mybenefits.life/documents. Whether a benefit program is fully-insured or self- funded is noted in Section 14.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 14 constitutes the wrap Summary Plan Description as required by ERISA § 102.

General Information about the Plan

Plan Name:	Fortinet, Inc. Health and Welfare Plan
Type of Plan:	Welfare plan providing coverages listed in Section 14. The Plan also includes a cafeteria plan under Code § 125 known as the Fortinet, Inc. Flexible Benefits Plan. The provisions of the Fortinet, Inc. Flexible Benefit Plan are summarized in Appendix C.
Plan Year:	January 1 to December 31.
Plan Number:	501
Effective Date:	January 1, 2009. The Plan has been amended several times since its original effective date, most recently as of January 1, 2025.
Funding Medium and Type of Plan Administration:	Some benefits under the Plan are self-funded, and some are fully-insured. See Section 14 for a description of the benefit programs and whether they are self-funded or fully-insured. For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO. The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below. For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The

	Company may hire a third party administrator (a "TPA") to process claims. Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable. The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.
Plan Sponsor:	The employer is the Plan Sponsor. Fortinet, Inc. 899 Kifer Rd Sunnyvale, CA 94086 (408) 235-7700
Plan Sponsor's Employer Identification Number:	77-0560389
Insurance Companies/HMO:	See a complete list under the heading Plan Provider Information later in this document.
Plan Administrator:	Attention: Benefits Manager Fortinet, Inc. 899 Kifer Road Sunnyvale, CA 94086 (408) 235-7700
Named Fiduciary:	Fortinet, Inc. 899 Kifer Road Sunnyvale, CA 94086 (408) 235-7700
Agent for Service of Legal Process:	President Fortinet, Inc. 899 Kifer Road Sunnyvale, CA 94086 (408) 235-7700 Service for legal process may also be made on the Plan Administrator.

3. Eligibility and Participation Requirements

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 14.

Certain benefit programs require that you make an annual election to enroll for coverage. ***Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the Plan except during annual Open Enrollment.*** However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 14. You must follow any required enrollment procedures. ***Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.***

Eligible Dependent Status

Section 14 and the individual benefit program describes whether your spouse and/or child(ren) (including the children of a domestic partner) can participate in a particular benefit program. Section 14 and the individual benefit program also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 14 and the applicable individual benefits program.

Note that who is eligible to be a dependent may be different for the different benefit programs offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the monthly method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 14.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical. benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance. ***Medicaid and State Children's Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health pla*****n*****Thus, this special enrollment event will not apply to such plans.***

Contract the Plan Administrator to request special enrollment under HIPPA.

The HIPAA special enrollment period may be extended due to COVID-19. Please see Section 6 for more information.

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 14 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 14 for a general summary of what happens when you terminate employment and the attached documents for specific termination events and information.

Coverage under certain benefit programs may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, and loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in Plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 14. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 14.

For the Health FSA benefit program, COBRA continuation coverage will not extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

4. Summary of Plan Benefits

Benefits and Contributions

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 14. A summary of each benefit program provided under the Plan may be

provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered “Creditable Coverage” under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, GINA, HIPAA, MHPA, MHPAEA, NMHPA, WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996

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

Women’s Health and Cancer Rights Act (WHCRA) of 1998

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. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call your Plan Administrator at (408) 235-7700.

GINA

Unless expressly permitted under GINA, with respect to each benefit program that is a group health program, the Plan will not: (i) request or require an individual to undergo genetic testing, (ii) adjust premiums or contribution amounts under the Plan based on genetic information of one or more Plan participants, or (ii) collect genetic information from an individual prior to or in connection with his enrollment in the Plan, or at any time for underwriting purposes.

MHPA and MHPAEA

To the extent the Plan provides treatment for mental illness and substance use disorders it will comply with the MHPA and MHPAEA which require a parity of treatment between the coverage of mental illness and substance use disorders and medical and or surgical conditions in certain areas including (i) copays, coinsurance and out-of-pocket maximums, (ii) limitations on service utilization, such as limits on the number of inpatient days or outpatient visits that are covered, (iii) the use of care management tools, (iv) coverage for out-of-network providers and (v) criteria for medical necessity determination.

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of "essential health benefits" are no longer permitted under the major medical plans offered by the Plan. For more information on "essential health benefits" refer to the terms of policies and benefit program materials listed in Section 14. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

COVID-19 Coverage

To the extent required by law, the Plan will comply with the COVID-19 diagnostic and reimbursement requirements set forth in the Families First Coronavirus Response Act and Coronavirus Aid, Relief and Economic Security Act and any subsequent guidance thereunder with respect to each benefit program that is a group health program offered under the Plan.

COVID-19 - Extended Timeframes

Guidance issued in response to the COVID-19 National Emergency requires the Plan to disregard the Outbreak Period when determining certain Plan deadlines. This means that deadlines related to HIPAA Special Enrollment events, COBRA notifications, elections and payments, and certain ERISA benefit claims and appeals rules may be delayed on an individual basis until the earlier of: (i) the end of the Outbreak Period, or (ii) one year from the original deadline (absent an extension). This guidance impacts applicable deadlines and timeframes that begin during the Outbreak Period as well as those that began prior to the Outbreak Period but that had not yet lapsed. The Outbreak Period is defined as the period from March 1, 2020, through 60 days after the announced end of the COVID-19 "National Emergency" (or such other time as the government agencies may announce in the future). While we don't know when the Outbreak Period will end, this relief from Plan deadlines is temporary. If you have any questions regarding the deadlines with respect to a benefit program please contact the:

- Claims Administrator for the benefit program with respect to claims and appeals
- Navia Benefit Solutions with respect to COBRA
- the Plan Administrator with respect to HIPAA special enrollment deadlines

5. Grandfathered Status under the Affordable Care Act

Grandfathered Benefit Programs

The Company has elected to maintain each of the following benefit programs as a "grandfathered health plan" as permitted by the Affordable Care Act:

- Cigna OAP 90/70
- Kaiser HMO

The Plan believes that each of the above listed benefit programs is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on "essential health benefits."

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (408) 235-7700. You may also contact the Employee Benefits Security Administration, US Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the US Department of Health and Human Services at www.healthcare.gov.

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Cigna Medical OAP 100/0
- Cigna Medical HDHP w/ HSA

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

Access to Primary Care Physicians

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

  For a list of health care professional who specialize in obstetrics or gynecology, contact Member Service for the benefit program you select at the number listed in Section 14.

6. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is 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. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 14, certain benefits under the Plan may be fully insured. The insurance companies are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

7. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 14. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit

program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator'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 or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as 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 insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

8. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

9. No Contract of Employment/No Assignment

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

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

10. Claims Procedure

The Plan’s claims procedures are contained in the applicable Benefit Descriptions and are furnished automatically in the separate Benefit Descriptions.

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures established by the Claims Administrator under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The Claims Administrator will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator or its delegate 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.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Claim Administrator a written claim on the form available from the Claim Administrator. The Claim Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Claim Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program. See the appropriate Benefits Description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

11. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: Cafeteria Plan, HSA and DCAP.

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under a group health program as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

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

Questions

If you have any questions about this statement or your rights under ERISA, 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.

12. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan’s subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person’s attorney’s fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan’s subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person

who received benefits under this Plan (even if such covered person is not made whole). The Plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The Plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any Employee, former Employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other

employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be an asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest $1 or $10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will have control with respect to which state's laws apply.

13. Benefit Program Information

Summary of eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program	Fully-insured or self-funded?	Policy or Group #	Who is eligible[2]	When Participation begins	When Participation Ends[3]	To File a Claim, Contact the Claims Administrator:
Medical[1] OAP, HDHP	Self-funded / Cigna	00358904	Full-time Employees working 30 or more hours per week	Date of hire	End of the month following date of termination	Member Services P. O. Box 188061 Chattanooga, TN 37422 (800) 244-6224
Medical[1] HMO	Fully-insured / Kaiser	629613	Full-time Employees working 30 or more hours per week	Date of hire	End of the month following date of termination	Member Services Claims: 320 Lennon Lane Walnut Creek, CA 94598 (800) 464-4000
Dental PPO	Self-funded / Cigna	00358904	Full-time Employees working 30 or more hours per week	Date of hire	End of the month following date of termination	Member Services P. O. Box 188061 Chattanooga, TN 37422 (800) 244-6224
Vision	Fully-insured / VSP	12252858	Full-time Employees working 30 or more hours per week	Date of hire	End of the month following date of termination	Member Services Claims: P.O. Box 385018 Birmingham, AL 35238 (800) 877-7195
Life and AD&D, STD, and LTD	Fully-insured / Lincoln Financial	06-066826	Full-time Employees working 30 or more hours per week	Date of hire	Date of termination	Member Services and Claims P.O. Box 7209 London, KY 40742 (855) 262-7974

[1] Including prescription drug.

Benefit Program	Fully-insured or self-funded?	Policy or Group #	Who is eligible[2]	When Participation begins	When Participation Ends[3]	To File a Claim, Contact:
EAP	Fully-insured / Modern Health	Fortinet	Full-time Employees working 30 or more hours per week	Date of hire	Date of termination	N/A
Commuter Benefits	Self-funded / Navia	N/A	Full-time Employees working 30 or more hours per week	Date of hire	Date of termination	Member Services P.O. Box 53250 Bellevue, WA 98015 (425) 452-3500
FSA	Self-funded / Navia	FOR	Full-time Employees working 30 or more hours per week	Date of hire	Date of termination	Member Services P.O. Box 53250 Bellevue, WA 98015 (425) 452-3500

[2] Generally you may also cover your spouse and children (including your domestic partner's children) up to age 26 although coverage after age 26 may be available for children who are incapacitated due to a disability and primarily dependent upon you for support. See the individual benefit program details for specific information about eligibility for coverage under that program.

[3.] Other Events (such as fraud or intentional misrepresentation of a material fact, etc.) can also terminate coverage -- see the benefit program details.

Appendix A: Cobra Continuation and Conversion Rights

COBRA Continuation

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA applies to the following benefit programs:

- CIGNA OAP 90/70
- Kaiser HMO
- Cigna Medical OAP 100/0
- Cigna Medical HDHP
- Cigna Dental
- VSP Vision
- Health Care Flexible Spending Account
- Modern Health EAP

Each of these benefit programs is referred to in this section as the "Plan," so you should read this section as if it applied separately to each Plan. COBRA continuation coverage is administered by Navia Benefit Solutions, which can be contacted by mail or by telephone at:

Member Services
P.O. Box 53250 Bellevue, WA 98015
(425) 452-3500

Complete instructions on COBRA, as well as election forms and other information, will be provided by Navia Benefit Solutions to Plan participants who become Qualified Beneficiaries under COBRA.

1. 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).

There may be other options available when you lose group health coverage**.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. 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.

2. 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 of 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 reason, 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. A domestic partner is not a Qualified Beneficiary.

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.

3. 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 the Employee's 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).

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a

proceeding in bankruptcy is filed with respect to the company and that bankruptcy results in the loss of coverage of any retired employee under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage 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, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will 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.

4. 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 total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Medicare eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up- change-plan.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

5. What is the procedure for obtaining COBRA continuation coverage?

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.

6. Are any of the deadlines discussed below extended for COVID-19?

Yes. Government guidance issued in response to the COVID-19 National Emergency requires the Plan to disregard the Outbreak Period when determining the following COBRA deadlines.

- The deadline to elect COBRA continuation coverage (normally 60 days starting on the date the election notice is sent)
- The deadline for the payment of COBRA initial premiums (normally 45 days after the COBRA election) or subsequent COBRA premiums
- The deadline to notify the Plan of a qualifying event, such as divorce or a dependent aging off the Plan, or determination of disability (normally within 60 days of the Qualifying Event or determination)

This means these deadlines related to COBRA notifications and elections and payments may be delayed on an individual basis until the earlier of: (i) the end of the Outbreak Period, or (ii) one year from the original deadline (absent as extension). The Outbreak Period is defined as the period from March 1, 2020, through 60 days after the announced end of the COVID-19 “National Emergency” (or such other time as the government agencies may announce in the future). If you have any questions regarding the COBRA deadlines with respect to a benefit program please contact Navia Benefit Solutions.

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

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 her or his 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, as extended by the Trade Preferences Extension Act of 2015, 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 themselves

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 about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

8. 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) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing 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:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Fortinet,Inc.
899 Kifer
Road
Sunnyvale, California 94086

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.

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 Navia Benefit Solutions 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 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 60-day election period described above, the right to elect continuation coverage will be lost.

9. 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.

10. 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 or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

11. 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 Company 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 entitled to Medicare (either part A or part B, whichever occurs earlier).In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) 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

(2) 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.

12. 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 enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 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.

(c) 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.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

13. 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- or 29-month period, by a second Qualifying Event that gives rise to a 36-months 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.

14. 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.

15. 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 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.

16. 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.

17. 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 by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or 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 until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

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.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan 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. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

18. How is my participation in the Health Care Flexible Spending Arrangement affected?

You can elect to continue your participation in the Health Care Flexible Spending Arrangement for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Care Flexible Spending Arrangement if you have “underspent” your account. In other words, you elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Care Flexible Spending Arrangement. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit. COBRA coverage will consist of the Company Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact Navia Benefit Solutions Member Services at (425) 452-3490. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep Navia Benefit Solutions informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or Navia Benefit Solutions. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

CALIFORNIA EXTENDED CONTINUATION OF COVERAGE RIGHTS FOR QUALIFIED BENEFICIARIES WHO ARE CALIFORNIA RESIDENTS ("EXTENDED CAL-COBRA")

If you are an Employee residing in California who elected coverage under the Kaiser HMO, you and/or certain family members may be eligible for additional "Cal-COBRA" benefits under the program described below. It is important to note that, in order to be eligible to receive Cal-COBRA coverage, you must have first elected to receive COBRA coverage.

(a) If you and/or your Qualified Beneficiary(ies) elected COBRA coverage and the maximum permitted time period for that coverage will end in less than 36 months, under California law you may be entitled to extend your medical plan coverage (but not vision or dental coverage) for up to a total of 36 months. For example, if you terminated service and your coverage was scheduled to end after 18 months, under Extended Cal-COBRA, you may be entitled to continue your coverage another 18 months, for a total of 36 months. To clarify, if you received a full 36 months of COBRA coverage, Extended Cal-COBRA is not available to you.

(b) You may elect to continue coverage for you and/or your Qualified Beneficiary(ies) by requesting an Extended Cal-COBRA extension from the Kaiser HMO at least 30 days prior to the end of your COBRA coverage period. Extended Cal-COBRA coverage will begin when your COBRA coverage ends.

(c) Your rate for Extended Cal-COBRA coverage may not exceed 110% of the applicable premium, unless you are eligible for an extension of coverage based on disability in which case your rate may not exceed 150% of the applicable premium.

(d) Premiums for Extended Cal-COBRA coverage will be billed by, and remitted to, the Kaiser HMO. Your failure to pay premiums will result in termination of Extended Cal-COBRA coverage for you and/or your Qualified Beneficiary(ies).

(e) Extended Cal-COBRA coverage for you and/or your Qualified Beneficiary(ies) will begin on the date your COBRA coverage expires and terminates on the earliest of:

(1) Your failure to pay the correct premium for extended coverage;
(2) Medicare entitlement;
(3) Coverage under another group health plan which does not impose any pre- existing condition limitations or exclusions or the date such pre-existing limitations or exclusions are satisfied;
(4) Your failure to satisfy the terms and conditions of the plan contract;
(5) You otherwise become ineligible for continuation coverage under California law; or
(6) Thirty-six months from the date that COBRA coverage began.

Appendix B: Medicare Part D

Medicare Part D Notice

Important Notice from Fortinet About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Fortinet 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. Fortinet has determined that the prescription drug coverage offered by the Fortinet, Inc. Health and Welfare 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 to 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 Fortinet coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Fortinet, Inc. Health and Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Fortinet prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Fortinet and don't join a Medicare drug plan within 63 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 nineteen 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 October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Fortinet 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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).

Date:	January 1, 2023
Name of Entity/Sender:	Fortinet
Contact-Position/Office:	Benefits Manager
Address:	899 Kifer Rd, Sunnyvale, CA 94086
Phone Number:	(408) 235-7700

Appendix C: Cafeteria Plan and FSA Provisions

Please refer to FSA SPD which starts on the next page.

FORTINET, INC.

FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

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FORTINET, INC.

FLEXIBLE BENEFITS PLAN

Summary Plan Description

INTRODUCTION

The Fortinet, Inc. Flexible Benefits Plan (the "Plan") allows you to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description or "SPD." We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Plan Administrator (or other plan representative). The name and address of the Plan Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our

group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the same day you can enter our group medical plan. See Section 14 of the Master Summary Plan Description for eligibility information.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan.

These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much

should go toward each benefit.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a participant to the extent of the premiums for such insurance unless you elect, during the election period (defined below), not to participate in the Plan.

4. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Plan Administrator and applied uniformly to all participants. It will normally be a period of time prior to the beginning of each Plan Year. The Plan Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Day Care Flexible Spending Arrangement, then there is a change in status if your dependent no longer meets the qualifications to be eligible for Day Care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Plan Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a benefit program is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Care Flexible Spending Arrangement, and you may not change your election to the Health Care Flexible Spending Arrangement if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Day Care Flexible Spending Arrangement if the cost change is imposed by a Day Care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under the sponsored group health plan if you are eligible to obtain coverage through the health exchanges.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will assume you want your elections for insured or self-funded benefits only to remain the same and you will not be considered a participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

IV
BENEFITS

1. Health Care Flexible Spending Arrangement

The Health Care Flexible Spending Arrangement enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our medical plan and save taxes at the same time.

The Health Care Flexible Spending Arrangement allows you to be reimbursed by the Employer for qualified health care expenses incurred by you and your dependents. You may be reimbursed for "over the counter" drugs. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Plan Administrator.

However, if you participate in a HSA, you can only be reimbursed by the Employer for out-of-pocket dental, vision or preventive care expenses incurred by you and your dependents. If you are a HSA participant, drug costs, including insulin, may be reimbursed if they are considered for dental, vision or preventive care expenses.

The most that you can contribute to your Health Care Flexible Spending Arrangement for the 2023 Plan Year is $3,050. After 2023, the dollar limit may be increased for cost of living adjustments. In addition, you will be eligible to carryover amounts left in your Health Care Flexible Spending

Arrangement, up to $610. This means that up to $610 that you do not use during the 2023 Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year.

In order to be reimbursed for a health care expense, you must submit to the Plan Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Plan Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

2. Day Care Flexible Spending Arrangement

The Day Care Flexible Spending Arrangement enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Day Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Day Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the Day Care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Day Care Flexible Spending Arrangement. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; or (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain Day Care expenses you may be paying for even if you are not a participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Day Care Flexible Spending Arrangement under our Plan. Ask your tax adviser which is better for you.

3. Premium Conversion Benefit

A Premium Conversion Benefit allows you to use tax-free dollars to pay for certain premiums under various insurance programs that we offer you. These premiums include:

-- Health care premiums under our self-funded medical plan.

-- Group term life insurance premiums.

-- Dental insurance premiums.

-- Disability insurance premiums.

-- Vision insurance premiums.

-- Accidental death and dismemberment insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of coverage that is available. Also, certain limits on the amount of coverage may apply.

The Plan Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your coverage will end when you leave employment, are no longer eligible under the terms of any coverage, or when coverage terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Plan Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

4. Health Savings Account or "HSA"

The HSA is available if you elect coverage under the CIGNA HDHP, are eligible to contribute to the HSA under federal tax law and you meet all of the eligibility requirements outlined in the HSA materials. You are not eligible to open or contribute to an HSA if you are: (i) covered by a non-high deductible health plan, (ii) enrolled in a regular health care spending account (either you or your spouse), (iii) covered under Medicare, Medicaid or Tricare or (iv) are someone else's tax dependent.

An HSA permits you to contribute a portion of your pay pre-tax (subject to IRS limits) to a separate account that is maintained by a trustee or custodian outside of the Plan. In 2023 the maximum amount that can be contributed to an Health Savings Account from all sources is $3,850 for self-only coverage and $7,750 for family coverage. These limits may be adjusted in future years.

In addition, each year that you elect coverage under the CIGNA HDHP your Employer will make contribution each plan year to your HSA (up to $750 if you elect "Employee only" coverage and up to $1,500 if you elect "Employee + Family). This Employer contribution will be made each January 1st and July 1st subject to your continued participation in the CIGNA HDHP and certain IRS rules. If you are hired after July 1st you will received a prorated contribution for the last 6 months of the year. You must have an HSA account with the HSA custodian in order to receive an Employer contribution. The IRS limits (from all sources) is $3,850 for an individual and $7,750 for family in 2023. If you will turn 55 during the calendar year (or you are older) you may contribute an extra $1,000 to your HSA account. Any unused funds remaining in your HSA at the end of the year automatically roll over to the following year and can be used for future eligible expenses, even if you are no longer employed by the Employer.

Funds in your HSA account may be used to pay for IRS-approved health care expenses. A list of eligible expenses can be found at irs.gov/publications/p502. If you use HSA funds for a nonqualified expense you will be subject to income tax and, if you are under 65 you will also owe a 20% penalty tax. The terms and conditions of the HSA are governed by the HSA trust or custodial agreement, which is not a part of this Plan. You may obtain a copy of the HSA trust or custodial agreement from the Plan Administrator. Any claims dispute you may have with respect to your HSA should be directed to the HSA trustee in accordance with the custodial agreement.

Contact the Plan Administrator for more information about enrolling in, or making contributions to, a Health Savings Account.

5. May I direct Plan contributions to my Health Savings Account?

Yes. If you are participating in the HDHP and you meet the eligibility requirements to make contributions to a Health Savings Account, any monies that you do not apply toward available benefits can be contributed to your Health Savings Account (subject to IRS limits), which enables you to pay for expenses which are not covered by our medical plan and save taxes at the same time. Please see your Plan Administrator for further details.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred under the Health Care Flexible Spending Account and Day Care Flexible Spending Arrangement. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. The provisions of the insurance contracts will control what benefits will be paid and when. You will only be reimbursed from the Day Care Flexible Spending Arrangement to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left in your Health Care Flexible Spending Account of Day Care Flexible Spending Arrangement at the end of the Plan Year will be forfeited, except for $610 in Health Care Flexible Spending Account that can be carried over in 2023 into the next Plan Year. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the both the Health Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. For the Day Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

Amounts in your Health Savings Account are not forfeited at the end of the Plan Year.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance, group-term life insurance and the Health Care Flexible Spending

Arrangement. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Care Flexible Spending Arrangement, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Care Flexible Spending Arrangement are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Care Flexible Spending Arrangement under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Plan Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying Day Care expenses incurred during the remainder of the Plan Year from the balance remaining in your Day Care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.

(c) Your Health Savings Account amounts will remain yours even after your termination of employment.

(d) For health benefit coverage and Health Care Flexible Spending Arrangement coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Care Flexible Spending Arrangement will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Care Flexible Spending Arrangement have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are participants who are officers, shareholders or highly paid. You will be notified by the Plan Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply.

You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Plan Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

IX
ADDITIONAL PLAN INFORMATION

1. General Plan Information

The Fortinet, Inc. Flexible Benefits Plan, originally effective on January 1, 2016, is part of the Fortinet, Inc. Health and Welfare Plan and Master Summary Plan Description (the “Master SPD”). Information about the Employer, Plan Administrator, Service of Legal Process, and Plan Administration can be found in Section 3 of the Master SPD.

2. Claims Process

Claims for expenses should be submitted to:

Navia Benefit Solutions, Inc.
PO Box 52350
Bellevue, Washington 98015

You should submit all reimbursement claims during the Plan Year. For the Health Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. For the Day Care Flexible Spending Arrangement, you must submit claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

If a Claim under the Plan is denied in whole or in part, you will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and

an explanation of the claims review procedure. .

A level one appeal under the Day Care Flexible Spending Arrangement must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of your appeal. You may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If you disagree with the level one appeal decision you may submit a request for a level two appeal to be determined by the Employer. You must submit a request for a level two appeal within 60 days of receipt of the level one notice. You will be notified within 30 days after the claims administrator receives the appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate Plan provisions.

Claims for benefits programs under Fortinet, Inc. Health and Welfare Plan Master Summary Plan Description (the "Wrap SPD") should be directed Claims Administrator identified in Section 14 of the Master SPD.

Decisions of the Employer are conclusive and binding.

In the case of a claim under Flexible Spending Arrangement, the following timetable for claims applies:

- Notification of whether claim is accepted or denied: 30 days
- Extension due to matters beyond the control of the Plan: 15 days
- Denial or insufficient information on the claim:
    - Notification of: 15 days
    - Response by participant: 45 days
    - Review of claim denial: 30 days
- Time to appeal a claim denial: 180 days
- Review of a claims appeal: 60 days

You must file your appeal by submitting a written request by email, fax, or mail. Indicate either level one or level two appeal on the email, fax, or letter.

Email:

claims@naviabenefits.com

Fax: 425-451-7002 or

866-535-9227

Mail: Navia Benefit Solutions, Inc. PO Box 53250 Bellevue, Washington 98015

Navia Benefit Solutions, Inc. will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

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

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

The Navia Benefit Solutions, Inc. will provide written or electronic notification of any denial on appeal. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(d) A statement of your right to bring a civil action under section 502 of ERISA.

If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

2. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

X
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Information about continuation coverage or conversion is contained in Appendix A

XI
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Plan Administrator.

APPENDIX I TO THE FORTINET, INC. FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

NOTICE OF PRIVACY PRACTICES

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

EFFECTIVE DATE: SEPTEMBER 23, 2013

This Notice of Privacy Practices ("Notice") describes the legal obligations of the Fortinet, Inc. Flexible Benefits Plan and your rights regarding your protected health information ("PHI") held by the [Fortinet, Inc. Flexible Benefits Plan (the "Plan"). PHI is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). PHI generally means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; 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 that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased.

This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes permitted or required by law.

We are required by law to:

- maintain the privacy of your PHI;
- provide you with the notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of the Notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer who assist in administration of the Plan. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action. Employer will establish a mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

Employer may not use or disclose your PHI other than as summarized herein or as required by law. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein.

HOW WE MAY USE AND DISCLOSE YOUR PHI

The following categories describe different ways that we use and disclose PHI for purposes of Plan administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations) We may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Treatment Purposes (as described in applicable regulations) We may use and disclose PHI to provide, coordinate or manage your health care and related services by one or more of your health care providers.

For Health Care Operations (as described in applicable regulations) We may use and disclose PHI

about you for other Plan operations. These uses and disclosures are necessary to administer the Plan.

To Business Associates, Subcontractors, Brokers, and Agents We may contract with entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing to implement appropriate safeguards regarding your PHI in a Business Associate Agreement. Our Business Associates shall also require each of its subcontractors or agents to agree in writing to provisions that impose at least the same obligations to protect PHI as are imposed on Business Associate by the Business Associate Agreement or by HIPAA.

As Required By Law We will disclose PHI about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Disclosure to Health Plan Sponsor Information may be disclosed to another health plan maintained by Employer for purposes of facilitating claims payments under that plan. In addition, PHI may be disclosed to Employer personnel solely for purposes of administering benefits under the Plan.

SPECIAL SITUATIONS

Organ and Tissue Donation If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans If you are a member of the armed forces, we may release PHI about you as required by military command authorities.

Workers' Compensation We may release PHI about you for workers' compensation or similar programs.

Public Health Risks We may disclose PHI about you for public health activities (e.g., to prevent or control disease, injury, or disability).

Health Oversight Activities We may disclose PHI to a health oversight agency for activities authorized by law.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors We may release PHI to a coroner or medical examiner. We may also release PHI about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official.

Research We may disclose your PHI for research if the individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

REQUIRED DISCLOSURES

Government Audits We are required to disclose your PHI to Health and Human Services ("HHS") in the event of an audit in order to determine our compliance with HIPAA.

Disclosures to you We are required to disclose your PHI to you. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for treatment, payment, or health care operations, and if the PHI was not disclosed pursuant to your authorization.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI:

Right to Inspect and Copy You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to your Human Resources Department. If the information you request is in electronic copy, and you request an electronic copy, we will provide a copy in electronic format unless the information cannot be readily produced in that format then we will work with you to come to an agreement on a different format. If we cannot agree, we will provide you with a paper copy.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

In certain very limited circumstances, we may deny your request to inspect and copy. If you are denied access to PHI, you may request that the denial be reviewed by your Human Resources Department.

Right to Amend If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to your Human Resources Department. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the PHI kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to Receive Notice of Breach You have a right to be notified upon a breach of your unsecured PHI.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures" of PHI made in the six years prior to the date on which the accounting is requested, except for disclosures:

- To carry out treatment, payment and health care operations as provided in §164.506;
- To individuals of PHI about them as provided in §164.502;
- Incident to a use or disclosure otherwise permitted;
- Pursuant to an authorization as provided in §164.508;
- To persons involved in the individual's care or other notification purposes as provided in §164.510;
- For national security or intelligence purposes as provided in §164.512(k)(2);
- To correctional institutions or law enforcement officials as provided in §164.512(k)(5);
- As part of a limited data set in accordance with §164.514(e); or
- That occurred prior to the compliance date for the Plan.

Please submit a written request of an accounting of disclosures to your Human Resources Department.

Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular claim with your spouse. To request a restriction, you must make your request, in writing, to your Human Resources Department. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid the health care provider “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications You have the right to request that we communicate with you about your PHI a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to your Human Resources Department. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy You have a right to a paper copy of this Notice. You may ask for a copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. Contact the Human Resources Department for a paper copy of this Notice.

CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE

We reserve the right to change this Notice of Privacy Practices that may be provided to you. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. The Notice will indicate the effective date on the front page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of HHS. To file a complaint with the Plan, contact your Human Resources Department. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us with an authorization to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization and that we are required to retain our records of the care that we provided to you.

Authorizations for Psychiatric Notes, Genetic Information, Marketing, & Sale In general, and subject to specific conditions, we will not use or disclose psychiatric notes without your authorization; we will not use or disclose PHI that is genetic information for underwriting purposes; we will not sell your PHI, i.e. receive direct or indirect payment in exchange for your PHI, without your authorization; we will not use your PHI for marketing purposes without your authorization; and we will not use or disclose your PHI for fundraising purposes unless we disclose that activity in this Notice.

Personal Representatives We may disclose your PHI to individuals authorized by you, or an individual designated as your personal representative, provided that we have received your authorization or some other Notice or documentation demonstrating the legal right of that individual to receive such information. Under HIPAA we do not have to disclose PHI to a personal representative if we have a reasonable belief that:

1) you have been or may be subjected to domestic violence, abuse, or neglect by such person; or
2) treating such person as your personal representative could endanger you; and
3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and other Family Members With only limited exceptions, we will send all mail to the employee. This may include information regarding a spouse or dependents also covered under the Plan. Information includes, but is not limited to, Plan statements, benefit denials, and benefit debit cards and accompanying information.

Appendix D: Summary of Material Modifications 2024

Summary of Material Modification
To Fortinet, Inc. Health and Welfare Plan

To: Employee participants in the Fortinet, Inc. Health and Welfare Plan, and COBRA participants

From: Andrew Dee, Director, Total Rewards and People Analytics

Date: January 1, 2024

The Fortinet, Inc. Health and Welfare Plan sponsored by Fortinet, Inc. has been revised. All of the changes summarized below are effective January 1, 2024.

- Cigna HDHP medical plan deductible changed to $2,000 for individuals and $4,000 for families.
- Fortinet's annual employer HSA contribution will increase to $1,000 for individuals, and $2,000 for families (funded on a per-pay-period basis).
- Health Savings Account (HSA) administration changed carriers from Cigna to Fidelity, now providing an integrated HSA and 401(k) experience.
- Modern Health EAP Implemented
    - You and your dependents have access to resources that support your emotional, professional, social, physical, and financial health. This includes 8 therapy and 8 coaching visits per year. Modern Health will replace Concern Employee Assistance Program (EAP).
- Cigna will no longer issues physical ID cards for medical or dental plans. Members can request physical cards by contacting customer service or via the MyCigna.com portal.
- Kaiser CA HMO Medical mandated the following program enhancements:
    - FDA-approved over-the-counter drugs and devices no longer require a prescription, and these treatments will be covered at no member cost share.
    - Vasectomy coverage is covered at no member cost share.
- Special Voluntary Life Open Enrollment –
    - You may purchase up to $500,000 of life insurance for yourself and $50,000 in spouse life insurance without submitting proof of good health — also known as evidence of insurability (EOI). Future coverage elections may require proof of good health.

Please contact me, the Benefits Manager (acting on behalf of the plan administrator, Fortinet, Inc.), if you have questions regarding the information in this SMM. I can be reached as follows:

E-mail: avierra@fortinet.com

Address: 909 Kifer Road, Sunnyvale, CA 94086

FILING INSTRUCTIONS
Please keep this memorandum with your copy of the Plan's Summary Plan Description (SPD), as it explains important changes that may affect your benefits (please contact me if you need another copy of the SPD).

ERISA INFORMATION
Plan Sponsor: Fortinet, Inc.

Sponsor's EIN#: 77-0560389

Plan Name: Fortinet, Inc. Health and Welfare Plan

Plan Number: 501

Plan Year: January 01, 2024 through December 31, 2024

Appendix D: Summary of Material Modifications 2023

Summary of Material Modification
To
Fortinet, Inc. Health and Welfare Plan

To: Employee participants in the Fortinet, Inc. Health and Welfare Plan, and COBRA participants

From: Andrew Dee, Director, Total Rewards and People Analytics

Date: January 1, 2023

The Fortinet, Inc. Health and Welfare Plan sponsored by Fortinet has been revised. All of the changes summarized below are effective January 1, 2023.

1. Cigna plans now cover specified travel expenses
2. Adding Fertility benefits on Cigna and Kaiser medical plans
3. Composite filings on posterior teeth are now covered under Cigna dental
4. Enhancing the frame and contact lens allowances on VSP vision plan
5. Health Savings Accounts (HSA) contribution limits have increased for 2023:
    - Annual limits for 2023 are $3,850 for individual coverage and $7,750 for family coverage

Please contact me, Andrew Dee (acting on behalf of the plan administrator, Fortinet), if you have questions regarding the information in this SMM. I can be reached as follows:

Phone: (408) 235-7700 ext. 81030

E-mail: adee@fortinet.com

Address: 899 Kifer Rd Sunnyvale, CA 94086

FILING INSTRUCTIONS
Please keep this memorandum with your copy of the Plan's Summary Plan Description (SPD), as it explains important changes that may affect your benefits (please contact me if you need another copy of the SPD).

ERISA INFORMATION
Plan Sponsor:

Sponsor's EIN#: 77-0560389

Plan Name: Fortinet, Inc. Health and Welfare Plan

Plan Number: 501

Plan Year: 2023

Summary of Material Modification
To
Fortinet, Inc. Health and Welfare Plan

To: Employee participants in the Fortinet, Inc. Health and Welfare Plan, and COBRA participants

From: Fortinet Human Resources Department

Date: January 1, 2025

The Fortinet, Inc. Health and Welfare Plan sponsored by Fortinet, Inc. has been revised. All of the changes summarized below are effective January 1, 2025. The Plan adopted the following material modifications:

1. The following plan design changes have been made to the Cigna OAP, OAP In and OAP HDHP medical plans:

- Addition of Table 2 guidelines for gender-affirming care - coverage of additional procedures including Blepharoplasty, rhinoplasty, voice therapy, and certain implants.
- Implementation of Virgin Pulse Core Well Being Solution offered through Cigna
- Removal of aggregate stop loss

2. The following plan design changes were implemented for the Cigna OAP 100/0 plan:

Cigna OAP 100/0 (in-network only)

Deductible	
Individual	$250
Family	$750
Out-of-pocket maximum	
Individual	$2,500
Family	$7,500
Coinsurance	0%
Office visit copays	
PCP	$25
Specialist	$25
Urgent care	$25
ER visit	$100 copay
Outpatient services	No charge after ded.
Inpatient services	$250 copay after ded.

3. IRS contribution limits for 2025:
    - Healthcare FSA: The IRS maximum contribution limit for 2025 is $3,300 with $660 carry over maximum.
    - Dependent Care FSA: The IRS maximum contribution limit for 2025 is $5,000
    - Parking & Transit: The IRS maximum contribution amounts for 2025 is $325.
    - HSA: The maximum Health Savings Account contribution limits for 2025 are:
        - Self-only: $4,300 per year
        - Family: $8,550 per year
        - HSA Catch-up Contributions: Remains at $1,000 for those age 55 and older
4. Plan Sponsor Address

    The address of the plan sponsor has changed. The new address is as follows:

    909 Kifer Road Sunnyvale, CA 94086

Please contact me, Rachel Lam (acting on behalf of the plan administrator, Fortinet, Inc.), if you have questions regarding the information in this SMM. I can be reached as follows:

Phone: (669) 444-0417

E-mail: lrachel@fortinet.com

Address: 909 Kifer Road, Sunnyvale, CA 94086

FILING INSTRUCTIONS
Please keep this memorandum with your copy of the Plan's Summary Plan Description (SPD), as it explains important changes that may affect your benefits (please contact me if you need another copy of the SPD).

ERISA INFORMATION
Plan Sponsor: Fortinet, Inc.

Sponsor's EIN#: 501

Plan Name: Fortinet, Inc. Health and Welfare Plan

Plan Number: 501

Plan Year: 1/1/2025 – 12/31/2025